Department of Health and Human Services
Centers for Medicare & Medicaid Services

Date Issued: December 3, 2001

Operational Policy Letter #: 2001.134

To:		
	Current M+C Organizations	X
	Section 1876 Cost Plans	X
	CBC Demonstrations	
	Evercare	X
	DoD (TriCare)	
	SHMO I & II	X
	PACE	
	OFM Demonstrations	
	MSHO	
	W.P.S.	
	HCPPs	X

Subject: Model M+C Plan Evidence of Coverage and Disclosure Information, January 1, 2002 through December 31, 2002

Effective Date: January 1, 2002

Implementation Date: December 3, 2001

Background:

Section 42 CFR 422.111(a)(3) requires that "An M+C organization must disclose ... information ... at the time of enrollment and annually thereafter." CMS believes that in order to be useful to enrollees and to meet requirements of the law and regulations, an updated Evidence of Coverage (EOC) needs to be sent to all enrollees no later than March 1, 2002. Beginning March 1 or after the organization has mailed the 2002 EOC to all members, whichever is earlier, the 2002 EOC must be mailed to new members no later than two weeks after the effective date of coverage.

The 2002 model EOC is attached. Also attached is a checklist that M+C organizations (M+COs) may use when submitting their EOC for review.

Please note that several sections of the 2002 model EOC were developed with considerable input from the managed care industry, beneficiary advocacy groups, and Medicare beneficiaries. In particular, CMS obtained input from the industry and advocacy groups and consumer tested the "Welcome letter," the Table of Contents/EOC organization, Section 9 (coordination of benefits language), Section 10/Appendix B (Appeals & Grievances), Section 11 (Disenrollment), and Appendix D (Advance Directives). In addition, much of the remainder of the model was re-written using actual M+CO EOC language to provide a more consumer friendly document. In the coming year, CMS plans to obtain similar input and to conduct similar consumer testing on the remaining sections of the EOC in order to complete a user friendly and effective 2003 model EOC that M+COs can use to expedite the marketing review process.

M+C organizations that follow this model without modification can receive an expedited (10-day) review of their EOC. For the EOC, "without modification" generally means using the terminology in this model verbatim or only making modifications where the model indicates modifications may be necessary. M+COs can still receive the 10-day review if they modify the following terms in the model to describe their plans and/or plan rules:

- "[Name of M+CO]," in which the word "we" or "[name of M+C plan]" is used in its place;
- "[Name of M+C plan]," in which the word "we" or "[name of M+CO]" is used in its place;
- "Member," in which the M+CO consistently uses another word (such as "customer") to describe the member;
- "Member Services," in which the M+CO consistently uses another word (such as "Customer Services") to describe member services. In addition, the M+CO may change any use of a departmental name (such as "Medicare Management Department") to refer to the correct name for its organization;
- "Primary Care Physician," in which the M+CO consistently uses another word (such as "Primary Care Provider") to describe the PCP;
- "Evidence of Coverage," in which the M+CO uses a different title for it's EOC (such as "Member Handbook");
- Any other word/phrase contained in this EOC (such as "plan provider") which is listed in the "Must Use/Can't Use/Can Use" chart in Chapter 3 of the Medicare Managed Care Manual as being another word/phrase that can be used to describe the word/phrase used in this model.
- "Self refer," in which the M+CO uses the word "direct access" instead.
- "Coverage," in which the M+CO uses the word "care" instead.
- Any reference to a responsibility for providing care, in which the M+CO would more accurately refer to a responsibility for providing access to care.

The M+CO may also still receive 10-day review if it:

- Deletes references throughout the EOC to a drug benefit (other than those drugs covered by Original Medicare), if the M+CO does not offer a prescription drug benefit.
- Adds references to its web site as an additional source of information for a particular topic.

CMS is suspending the final verification requirement for the 2002 EOC. The organization will not be required to send the Regional Office a "camera ready copy" of the EOC before it can print and mail the document. Instead, the organization must send a copy of what is mailed to all members to the Regional Office at the same time it is mailed to members.

NOTE: This model is written for all M+C organizations (excluding Private Fee-for-Service plans). All other Medicare managed care organizations and demonstrations that are required to send an EOC to their members (including PFFS plans) may base the format and organization of their EOC on this model, since it is considered by CMS to be an acceptable format. Of course, these entities must modify the language in their respective EOCs to conform with the statutory and regulatory requirements under which they operate. A Reference Guide for cost plans has been attached to aid in conversion of their EOCs from M+C to cost plan rules.

Contact: CMS Regional Office Managed Care Staff
This OPL was prepared by the Center for Beneficiary Choices

EVIDENCE OF COVERAGE:

Your Medicare Health Benefits and Services as a Member of [*Name of M+CO and/or Plan]*

January 1 – December 31, 2002

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document, so please keep it in a safe place.

[Name of M+CO] Member Services:

For help or information, please call Member Services *[insert days of week], [insert hours]*. Calls to these numbers are free:

1-xxx-xxx-xxxx

TTY: 1-xxx-xxx-xxxx (This number is for people who have difficulties with hearing or speech. You need special telephone equipment to use it.)

Welcome to [*name of M+C plan*]!

We are pleased that you've chosen *[name of M+C plan]*. [*Name of M+C plan*] is a Medicare managed care plan. It is a/an *[list type of coordinated care plan, i.e., HMO, PSO, PPO*]) offered by *[name of M+CO]*. This booklet, together with your enrollment form *[insert if applicable any reference to riders or other optional coverage selected]* and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of *[name of M+C plan]*. It also explains our responsibilities to you.

The information in this booklet is in effect for the time period from January 1, 2002, through December 31, 2002.

You still have Medicare, but now you are getting your Medicare services as a member of *[name of M+C plan]*. This booklet gives you the details, including:

- What is covered in *[name of M+C plan]* and what is not
- What you will have to pay for your health plan and when you get care
- How to get the care you need, including some rules you must follow
- What to do if you are unhappy about something related to your coverage or payment for care
- How to leave *[name of M+C plan],* including your choices for continuing Medicare if you leave, and new rules from the Medicare program about when and how often you can make changes

The *Table of Contents* on the next page will help you find the information you need. As you'll see in the Table of Contents, we've included an appendix that gives definitions for important words that we use in this booklet.

Table of Contents

Continued on next page

Continued on next page

SECTION 1. Telephone numbers and other information for reference (how to contact *[name of M+CO]* Member Services and other organizations, including the Medicare program (CMS), State Health Insurance Assistance Programs (SHIPs), Peer Review Organizations (PROs), state Medicaid agencies, and the Social Security Administration)

How to contact [name of M+CO] Member Services

If you have any questions or concerns, please call or write to *[name of M+CO]* Member Services. We will be happy to help you. Our business hours are *[insert]*.

CALL *[insert number]*. This number is also on the cover of this booklet for easy reference. *[Note to M+CO, add if applicable:* Calls to this number are free.] *[M+COs may also include reference to 24-hour lines here]*

TTY *[insert number]*. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. It is also on the cover of this booklet for easy reference. *[Note to M+CO: Add if applicable:* Calls to this number are free.]

FAX *[insert number][Note to M+CO: fax numbers are optional]*.

WRITE *[insert address – M+CO may also include E-mail address here]*

How to contact other organizations:

CMS (Centers for Medicare & Medicaid Services) -- the Medicare program

CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. CMS is the federal agency in charge of the Medicare program. Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS contracts with and regulates Medicare managed care organizations (including *[name of M+CO]*) and Medicare Private Fee-for-Service health plans.

Here are several ways for you to get help and information about Medicare from CMS:

- Call the national Medicare helpline to ask questions or ask for free copies of information materials produced by the Medicare program. Call 1-800-MEDICARE (1-800-633-4227), 24

hours a day, 7 days a week. The TTY number is 1-877-486-2048 (this number requires special telephone equipment and is used by people who have difficulties with hearing or speaking). Calls to these numbers are free.

- Use a computer to look on the Internet at www.medicare.gov on the national Medicare program website. The website includes a great deal of information about Medicare, including booklets you can print. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

"SHIP" -- a state organization that provides Medicare help and information

"SHIP" stands for **S**tate **H**ealth **I**nsurance Assistance **P**rogram. SHIPs are state organizations that receive money from the Federal Government to give free health insurance counseling and assistance to people with Medicare. For example, SHIPs help people with Medicare by providing information about Medicare rights and protections, and help with complaints about care or treatment. They can help with issues related to Medicare bills and choosing a Medicare health plan. They can also provide information about Medigap (Medicare supplement insurance), including describing special Medigap rights for people who have tried a Medicare +Choice plan (like *[name of M+C plan]*) for the first time. SHIPs have different names depending on which state they are in.

Here is how to contact the SHIP in your state: *[NOTE TO M+CO: Insert name, address, and telephone number for all applicable SHIPS]*. You can also find the website for your local SHIP at www.medicare.gov on the web.

"PRO" – an organization of health professionals who review medical care

"PRO" stands for **P**eer **R**eview **O**rganization. The PRO is a group of practicing doctors and other health care experts who are paid by the Federal Government to check and improve the care given to Medicare patients. Upon request, the PRO also reviews hospital discharges for appropriateness and quality-of-care complaints (see Section 10 of this booklet for more information about these types of review by the PRO).

There is a PRO in each state. PROs have different names, depending on which state they are in. Here is information about how to contact the PRO in your state: *[insert the name, address, and telephone number for all applicable PROs]*.

Medicaid agency – a state government agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state medical assistance program. Some people with Medicare are also eligible for Medicaid. Unlike Medicare, Medicaid may cover long-term care, such as custodial nursing home care. Even if you are not eligible for health services under Medicaid, Medicaid may cover all or part of your Original Medicare premiums and/or deductibles and coinsurance, if your income and resources are low enough. Contact your state Medicaid agency to find out about Medicaid. You can call us at the number on the cover of this booklet or your state Medicaid agency for information on related

programs including Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual, and Qualified Individual.
[NOTE TO M+CO: Insert name, address, and telephone number for all applicable state Medicaid agencies/state departments of health and social services].

Social Security Administration

The Social Security Administration programs provide economic protection for Americans of all ages. The types of programs administered through Social Security include retirement benefits; disability; family benefits; survivors' benefits; needs-based benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. The TTY number is 1-800-325-0778 (this number requires special telephone equipment and is used by people who have difficulties with hearing or speech). Calls to these numbers are free. You can also visit www.ssa.gov on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). The TTY number, which requires special telephone equipment and is used by people who have difficulties with hearing or speech, is 312-751-4701. You can also visit www.rrb.gov on the web.

Employer (or "Group") Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits or the open enrollment season.

SECTION 2. Getting started as a member of *[Name of M+C plan]*

(what it means to be in a managed care plan, your rights and responsibilities, your membership card, confidentiality of your medical records)

What it means to be in a managed care plan

You still have Medicare, but you are getting your Medicare now as a member of *[name of M+CO]*, which has a Medicare managed care plan. *[Name of M+CO]* is not a "Medigap" or "Medicare supplement insurance" policy that pays your Medicare deductibles and coinsurance. Instead, *[name of M+CO]* has a contract with Medicare to arrange your health care when you enroll in *[name of M+C Plan]*. As a member of *[name of M+C plan]*, you will no longer have to pay Original Medicare deductibles and coinsurance charges because we will cover all services and supplies offered by Original Medicare *[insert the following phrase if it applies to your plan*: plus some additional services and supplies not covered by Original Medicare]. This booklet explains the benefits and services that are covered for you as a member of *[name of M+C plan]*, and what you have to pay.

The Medicare managed care plan you've chosen, *[name of M+C Plan]*, is a *[list type of coordinated care plan, i.e., HMO, PSO, PPO*] offered by *[name of M+CO]*. By enrolling in *[name of M+C Plan]*, you have decided to get all of your health care, except in special situations, from *[name of M+C Plan]* providers and facilities. As explained in the next section, you must also follow all plan member rules, such as getting referrals and approval in advance (called "prior authorization") for services when required. Of course, if you need emergency or urgently needed services or out-of-area renal dialysis services, those services will be covered. However, if you receive any other services from non-plan providers (providers who are not part of [*name of M+C plan]*) without prior authorization neither *[name of M+CO]* nor Original Medicare will pay for those services.

Your membership card

[Insert Membership Card Diagram here – front and back]

Carry your membership card with you at all times

Now that you are a member of *[name of M+C plan]*, you have a *[name of M+C plan]* membership card. You must now start using your membership card to receive covered services. Because your membership card carries important information, please carry it with you at all times. You may need to show this card at the doctor's office or emergency room. You may also need it to get your prescriptions at the pharmacy. If your membership card is ever damaged, lost or stolen, please notify Member Services as soon as possible. We will replace your card.

What should you do with your red, white, and blue Medicare card?

Put your red, white, and blue Medicare card away in a safe place, and **do not use it** to get services while you are a member of *[name of M+C plan]*. It is very important that you use only your [*name of*

M+C Plan] membership card to get services and **NOT** your Medicare card. Otherwise, you might get services from non-plan doctors or the hospital might not know that it needs to notify your usual *[name of M+C plan]* doctor (called your Primary Care Provider, or "PCP") or *[name of M+CO]* that you are receiving care in the emergency room.

Help us keep your member records up to date

Your membership record has information from your enrollment form including your address and telephone number. It also shows your specific *[name of M+C plan]* coverage *[insert as appropriate: and the Primary Care Physician/Medical Group/IPA you chose when you enrolled]*. These records are very important because they identify you as an eligible *[name of M+C Plan*] member and may determine where you can get services.

Please report any changes in your name, address, or phone number to Member Services as soon as they occur. You should report any changes in health insurance coverage you have from your employer or your spouse's employer, and let us know if you have been admitted to a nursing home. You should also report any liability claims (such as claims against another driver in an automobile accident), eligibility under workers' compensation, and Medicaid eligibility.

Please tell us how we're doing

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time. Section 1, *Telephone numbers and other information for reference*, tells how to contact us. Your comments are always welcome, whether they are positive or negative.

In addition, we may ask about your experience with *[name of M+C Plan*] through member satisfaction surveys. These surveys give us useful information about our providers and the quality of our program. We hope you will participate if you are contacted in a member survey, because your responses and comments help us identify our strengths and areas for improvement.

Your rights and responsibilities as a member of [name of M+CO]

Your rights as a member of *[name of M+CO]* are summarized below.

You have the right to get health care services in a language you can understand and in a culturally sensitive way, and to be treated with dignity, respect, and fairness at all times. This includes the right to have someone help you with any language, physical, or communication barrier you may face. It includes the right to be protected from discrimination due to your race, ethnicity, national origin, gender, sexual orientation, age, religion, cultural or educational background, economic or health status, physical or mental ability, or the source of payment for your care.

You have the right to privacy and confidentiality of your medical records and personal information. This includes the right to talk with your health care providers in private, and to have us keep confidential all communications about your care and all information in your medical records. In

addition, any personal information that you give us when you enroll in this plan is protected and will remain confidential. We will make sure that unauthorized individuals cannot see or change your records.

- We must get written permission from you, or from someone you designate, before we give your medical information to anyone who is not directly providing your care or responsible for paying for your care, except for purposes that are specifically permitted by State and Federal laws or requirements (such as for use by programs that review medical records to monitor quality of care or to combat fraud and abuse).
- You have the right to look at, or get a copy of, your medical records. You may be charged a fee for copying your records.

You have the right to get information about your coverage and costs as a member of *[name of M+CO]* that is easy to understand. This includes getting information about which medical services are covered and not covered by *[name of M+C plan]*, what costs are covered by *[name of M+C plan]*, what you must pay, and what to do if you have a concern or complaint.

You have rights related to making complaints. These include the right to file a complaint (called a "grievance") about the quality of care you receive, waiting times at the doctor's office, the physical conditions of the doctor's office, and other types of complaints which are explained in Section 10. You also have the right to complain about getting medical care or payment for care you have received (called a request for reconsideration or appeal). You have the right to have us be fair in examining and addressing all complaints, and to not discriminate against you if you complain. You have the right to get information about the grievances and appeals that members have filed against *[name of M+CO]*.

You have rights that are related to getting medical services, including timely access to plan providers and all services covered by *[name of M+C plan]*. As explained in this booklet, you will get most or all of your care from plan providers, that is, from doctors and other providers who are part of *[name of M+C plan]*.

- You have the right to choose a qualified provider who is part of *[name of M+C plan]* (we will tell you which doctors are not accepting new patients).
- You have the right to timely access to your Primary Care Provider (PCP) and referrals to specialists when medically necessary.
- You have the right to get emergency care when and where you need it. We will pay for emergency services without giving our approval in advance if you, acting as a "prudent person," believe that you have a medical condition that requires emergency treatment.
- You have the right to receive urgently needed services when traveling outside of *[name of M+C plan]*'s service area. Also, while you are inside the service area, you have the right to receive urgently needed care from providers who are not part of *[name of M+C plan]* if unusual circumstances keep you from getting care from your PCP or other plan provider.

You have the right to get explanations and other information whenever you receive medical care (understanding that it may be difficult or impossible to provide full information during an emergency). This includes the right to get information about your providers, including the names and qualifications of the doctors and other health care professionals involved in your medical care. When you see a doctor or other provider, you have the right to receive an explanation of your medical condition using language you understand. This includes all of the following:

- To be told about any medical risks involved in your treatment, and about alternative treatments and their risks.
- To know about your prospects of recovering from your illness or injury, and be told of the risks if you refuse any treatments.
- To know whether your medical care or treatment is part of a research experiment, and to refuse any experimental treatments.
- To be informed about any medications you are told to take, how to take them, and their possible side effects.
- To know whether you need any continuing treatments, and to get the time and place of your appointment and the name of your provider.

You have the right to participate fully in decisions about your health and treatment options, and to make informed decisions. Your rights include the following:

- To be given information about treatments or procedures that are recommended for your condition, regardless of what they may cost or whether they are covered by *[M+C plan name]*.
- To have someone help you make decisions, or to give another person the legal responsibility to make decisions about medical care on your behalf.
- To refuse treatment or leave a medical facility, even against the advice of your doctor (and you accept the responsibility if you do this).
- To ask your doctor to withhold or withdraw treatments that could prolong your life, if you have been diagnosed as terminally ill and anticipate that you will eventually be unable to make your own decisions about health care.
- To complete an Advance Directive, a "living will" or other legal document that gives your medical provider instructions about your wishes for medical care in the event that you are unable to make your own decisions (see Appendix D for information about Advance Directives).

You have rights as a hospital patient. When you are hospitalized, you should receive a document called *Important Message from Medicare*, which explains your rights as a hospital patient. These include the right to be told why you are being discharged (released from the hospital), and what to do if you feel you are being discharged too soon.

You have the right to an explanation from us about any bills you may receive for services not covered by *[name of M+C plan]*, including the right to file a request for reconsideration or "appeal" our decision to not cover a service (see Section 10).

You have the right to get certain information about *[name of M+CO]*, including information about our financial condition, how we compensate our plan providers, and information about how *[name of M+C plan]* compares to other health plans.

Along with the rights you have as a member of *[name of M+C plan]*, you also have some responsibilities, which include the following:

- To become familiar with your coverage and the rules you must follow to get care as a member of *[name of M+C plan]* by reviewing this booklet and other information you receive from *[name of M+CO] [Note to M+COs: insert specifics about other information if applicable]*.
- To ask your doctor if you have any questions, and to give your doctor and other providers the information they need to care for you.
- To follow treatment plans, instructions, and care that are agreed upon by you and your doctors.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To pay your plan premiums as a member of *[name of M+C plan]*, to pay any copayments that are part of your covered medical services, and to meet your other financial responsibilities that are described in Section 9 of this booklet.
- To call *[name of M+CO]* Member Services at the telephone number on the cover of this booklet if you have any questions, suggestions, or problems with your care or payment.

SECTION 3 Getting the care you need, including some rules you must follow *([Name of M+C plan]*'s service area, using plan providers to get your care, your Primary Care Provider, getting care from specialists, when you *do* and do *not* need a referral from your PCP, changing doctors, getting care when the doctor's office is closed, getting care when you are traveling or away from home)

What is the geographic "service area" for [name of M+C plan]?

You can enroll in *[M+C plan]* and get covered services as long as you live in the plan's service area:

[*Insert plan service area listing. If approved for entire county use county name. Use zip codes for partially approved counties only.]*

Using plan providers to get your care

As a member of *[name of M+C plan]*, you will get most or all of your care from "plan providers."

"**Providers**" is the general term we use for doctors, hospitals, health care professionals, and health care facilities that are licensed and/or certified by Medicare and by the State to deliver or furnish health care services.

- We call them "**plan providers**" when they are part of *[name of M+C plan]* – that is, when we have contracted or arranged with them to coordinate or provide covered services or supplies to members of *[name of M+C plan]*.
- We call them "**non-plan providers**" when they are **not** part of *[name of M+C plan]*.

Now that you are a member of *[name of M+C plan]*, you will be getting your covered medical care and services from **plan providers,** with just a few exceptions that are described in this booklet. For a complete list of plan providers, please refer to the *[name of M+C Plan]* Provider Directory. *[M+COs may also note that a complete list of plan providers is available on their website (give website address)]*. If you have any questions about the providers listed in the directory, please call Member Services at the telephone number on the cover of this booklet.

Your PCP (Primary Care Provider) will coordinate all of your care

What is a "PCP" and how do you get one?

As a member of *[name of M+C plan]* you will have a PCP who coordinates all of your care. "PCP"

stands for [*insert acronym used by the plan:* **Primary Care Physician/Primary Care Provider].** Your PCP is a health care professional who is trained to give you basic care. Your PCP is responsible for providing or coordinating covered services while you are a member of [*name of M+C Plan*].

[M+CO: Explain how a member chooses a PCP, e.g., by using the Provider Directory or getting help from Member Services. Explain that if the member would want to be admitted to a particular hospital, s/he should ask to which plan hospitals the PCP has admitting privileges]. The name and office telephone number of your PCP is printed on your membership card.

What is "lock-in" and how does it work?

As a *[name of M+C Plan]* member, all of your routine health care is provided and arranged by your PCP. Your specialty care, x-rays, laboratory tests, therapy, prescription medications, hospital admissions and follow-up care will also be provided, authorized, or coordinated by your PCP. **This is known as "Lock-In."** If you go to a doctor, hospital, or other provider without the approval of your PCP --except in an emergency or when you need urgent care, out-of-area renal dialysis, or certain gynecological care or other self referred services-- you will be responsible for paying any charges for these services. Neither Original Medicare nor *[name of M+CO]* will pay for non-emergency services or non-urgently needed care without the prior authorization of your PCP. *[Note: Plans may cross-refer to information about any exceptions to the "Lock-In" Feature.]*

[Note: Modify this section to reflect your own contractual circumstances. If your plan uses formal referral circles where each enrollee, by selecting a specific PCP, is also selecting an entire sub-network to which his or her PCP can make referrals, include detailed information on the nature of the sub-network, provider types, referral practices and policies.]

The "lock-in" feature is important to you and *[name of M+CO]*. We are able to offer you this plan because of our contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that oversees Medicare. Under this contract, the Federal Government agrees to pay us a fixed monthly dollar amount for each member we serve. Since we use this monthly amount to contract with medical groups, hospitals, and other plan providers to arrange your care, you need to use these plan providers to get your covered services.

Getting care from your PCP

Since your PCP will coordinate all of your medical care, you should have all of your medical records sent to his/her office. This way your PCP will be able to look at your medical records to see if you have any existing health conditions and to coordinate your care.

If at all possible, call your PCP 24 hours in advance if you cannot keep a scheduled appointment.

If you need to talk to or see your PCP after his or her office has closed for the day, call *[insert 24-hour # or, if there is no #, directions for calling after hours]*. There will always be a *[physician, plan provider]* on call to help you. This physician will call you back and advise you about what to do. [*The*

M+CO should make arrangements for the hearing impaired to have access to a 24-hour number. This could be a "relay" number the member can use to contact their PCP after hours.]

The twenty-four (24) hour emergency and/or urgent care telephone numbers are *[state where the numbers are located, such as "in the Provider Directory" or "on your membership card"]*.

Getting care from specialists

Even though your PCP is trained to handle most of your common health needs, there may be times when he or she feels you need more specialized treatment. In that case, you may receive a referral (written permission) to see a specialist *[Note to M+CO: Those M+COs that have electronic and not written referrals should delete the parenthetical "(written permission")]*. Specialists are doctors who provide health care services for a specific disease or part of the body. Examples include oncologists (care for cancer patients), cardiologists (care for the heart), and orthopedists (care for bones).

Please note the following:

- It is very important to get a referral from your PCP before seeing a specialist. **If you don't have a referral before you receive the services, you may have to pay for these services yourself**. As explained later in this section, there are a few services you can get on your own, without a referral or other involvement of your PCP.
- If your specialist recommends that you continue to see him/her for more services, check first with your PCP to be sure your referral covers any additional visits to the specialist. *[M+COs modify this sentence as needed to describe process for referrals for follow-up specialty care.]*
- PCPs often have certain specialists they use for referrals. **Depending on who you chose as your PCP, you may be limited to what specialists you can see.** *[M+COs: Modify this section as appropriate if your plan has open access panels.] [M+COs should modify the PCP/specialist phrase to reflect the plan's own contractual circumstances. If your plan uses formal subnetworks where each enrollee, by selecting a specific PCP, is also selecting an entire subnetwork to which his or her PCP can make referrals, you should include a complete explanation of this restriction here.]* Please be sure to consult with your PCP if there are specific specialists or facilities that you want to use.
- In some cases, our Medical Management Department must give prior approval for a referral. Your PCP will request this approval and let you know if it is given.

There are some services you can get on your own, without a referral

You do not always need a referral to see certain specialists or get services. You are allowed to go on your own, without a referral, for the following services -- as long as you get these services from a **plan provider:**

- Routine women's health care (mammograms, pap tests, and pelvic and breast exams)

- Flu shots and pneumococcal vaccinations
- *Insert any other services for which M+CO allows self referrals*

It is called "**self-refer**" when you get these services without a referral from your PCP.

Changing doctors

How to change your PCP (Primary Care Provider)

You may change your PCP at any time [*mention of any limits on when the change may occur, such as "at the end of the month"]*. Simply call Member Services and we will check to make sure the doctor you choose is accepting new patients. *[M+COs insert the following sentence if it applies to the particular provider arrangement:* You should also ask whether the PCP has a referral relationship with any specialist you are currently seeing. Also, please let us know if you are getting home health agency services or using durable medical equipment so we can help with the transfer of your care or equipment.*]* We will make the change for you and tell you over the phone when this change will go into effect *[insert as appropriate:* and send you a new membership card*]*.

What if your doctor leaves *[name of M+C plan]*?

Sometimes a PCP, specialist, or clinic you are using might leave the plan. If this happens, you will have to switch to another plan doctor. We will notify you if this happens and make sure you continue to have access to all services in *[name of M+C plan]*'s benefit package.

The doctor-patient relationship

We do not prohibit or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on your behalf about:

- your health status, medical care, or treatment options;
- the risks, benefits, and consequences of treatment or non-treatment;
- your right to refuse treatment and to express preferences about future treatment decisions.

Getting care when you travel or are away from the service area

When you are outside *[name of M+C plan]*'s service area, we will only pay for emergency services, urgently needed services, out-of-area dialysis, and care that we have approved in advance. Be sure to check with Member Services at the telephone number on the cover of this booklet if you have questions about what medical care is covered when you travel. *[M+COs that offer traveler benefits to members who are out of your service area, such as a POS or travel benefit – modify as appropriate and describe the travelers benefits and rules related to receiving the out of area coverage.]*
If you plan to permanently move or be away from the service area for more than six months, we will have to disenroll you. For more information, see Section 11.

SECTION 4 Getting care if you have an emergency or an urgent need for care

Getting care if you have an emergency

You are covered for emergency medical conditions whether you are inside or outside the service area. [*If you offer a "world-wide" emergency benefit, then you should say so here. You can say:* "We also offer world-wide emergency coverage."]

An **"emergency medical condition"** is a condition brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not getting immediate medical attention could result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

"Emergency services" are covered services that are given by any qualified provider, and needed to evaluate or stabilize an emergency medical condition.

In an emergency, go to the closest emergency room or call 911 for help. **You do not need prior authorization for treatment of emergency medical conditions.** However, it is best if you can have someone telephone *[[name of M+CO] or your PCP or your medical group]* as soon as possible so they can know you are being treated. The number to call is located on your *[name of M+C Plan]* membership card.

Even if you can't make the call when you are being treated, please have someone notify [*[name of M+CO], PCP, medical group or IPA]* that you were treated for an emergency medical condition as soon as possible, preferably within 48 hours. This will ensure that *[he/she or we or they*] can help manage your health care and can arrange your transfer when your medical condition is stable (as determined by your treating physician).

If you are treated for an emergency medical condition while out of the service area, we prefer that you return to the service area to receive follow-up care through your PCP. However, we will cover services given out of the service area as long as the care you need still meets the definition for either emergency services or urgently needed services.

Post stabilization care

In most cases, if the emergency room physicians determine that you do not have an emergency medical condition, we will not cover any additional care that you receive if you are seeing non-plan providers. However, if you have had an emergency medical condition, we will cover medically necessary services related to the emergency from the time the non-plan provider requests authorization from us until:

- a plan provider assumes responsibility for your care; or
- we agree with the non-plan provider on a treatment plan for you; or,
- under certain circumstances, you are discharged.

Getting care if you have an urgent need for care that is not an emergency

What are "urgently needed services"?

"Urgently needed services" are immediately needed as a result of an unforeseen illness, injury, or condition when it is not reasonable given the circumstances to get the services through your PCP or other plan providers. Ordinarily, these services are provided when you are out of the service area. In extraordinary cases, these are services provided when you are in the service area but plan providers are not available.

Getting urgently needed services when you are <u>outside</u> the plan's service area

If you need urgent care when you are out of the *[name of M+C plan]* service area, we ask that, if possible, you first telephone your PCP. If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to receive follow-up care through your PCP. However, we will cover follow-up services given out of the service area as long as the care you need still meets the definition for urgently needed services.

Please remember that routine or elective medical services not authorized by *[Name of M+CO]*, which are provided by non-plan providers, are not covered services. Neither *[Name of M+CO]* nor Original Medicare will pay for such services. One exception: renal dialysis services are covered while you are temporarily out of the service area (for up to six months in a row) and *[name of M+C plan]* will cover these services. *[M+CO: may insert special instructions here, e.g., may need to know before you leave the service area where you are going to be so they can coordinate or arrange for you to have maintenance dialysis while outside the service area]*)

Getting urgently needed services when you are <u>in</u> the plan's service area

Even though urgently needed services usually apply to care when you are out of the service area, sometimes you might feel that you need immediate medical advice or care even when you are in the service area. In these situations, please call your PCP or *[insert 24-hour number or, if there is no 24-our hotline, other directions for calling when the PCP is not available]* for instructions.

SECTION 5 Your coverage – the medical benefits and services you get as a member of *[name of M+C plan]* (an introduction to your benefits followed by a chart that lists your coverage for each type of benefits and services, with a section at the end that tells how you can purchase additional benefits)

Introduction to your medical care benefits and services

This section describes the benefits and coverage you get as a member of *[name of M+CO]*. Here is a definition of a term that we use:

Covered Services – The medically necessary benefits, services and supplies listed in the "Schedule of Medical Benefits" in this section, which are:

- Services provided or furnished by *[name of M+C plan]* plan providers *[or authorized by its plan providers*].
- Emergency services and urgently needed services which may be provided by plan providers and non-plan providers (Please see Section 4 for more information about emergency services and urgently needed services).
- Post-stabilization services furnished by non-plan providers or facilities that are authorized by us or were not pre-approved because *we* did not respond to a request for pre-authorization for such services within 1 hour of the request (or because we could not be contacted for pre-authorization).
- Renal dialysis services provided while you are temporarily outside the service area.

Can benefits change?

Between January 1, 2002 and December 31, 2002, we can increase your benefits, but we cannot reduce them. (However, we can change our prescription drug formulary at any time during the year – this topic is discussed in *Section 6, Using your coverage for prescription medicines*.) Decreases in your benefits are only allowed at the beginning of each calendar year, and they must be approved by the Medicare program. We will let you know in October 2002 if there will be any changes in your benefits beginning January 1, 2003. We will also let you know in writing if we plan to increase your benefits in 2002.

Your Schedule of Medical Benefits

Notes to M+COs:

1. *For all chart sections that follow, M+CO must use asterisks/footnotes with services that require prior authorization.]*
2. *M+COs that use one EOC for multiple plans may create this section as an insert to the EOC.*
3. *M+COs may list optional supplemental benefits in this Schedule, but when doing so, must make it clear if additional premiums are required and must refer reader to Section 5 for more information.]*
4. *M+COs may include additional categories of benefits not included in this model Schedule (such as dental riders, maternity/infertility benefits, disease management programs).*

All coverage will be provided in accordance with Medicare guidelines.

Covered Services	What You Pay for Covered Services
Inpatient Hospital Care - For more information, see *Section 7.* Semiprivate room (private if medically necessary); Meals including special diets; Regular nursing services; Costs of special care units, e.g., intensive or coronary care units; Drugs and medications; Lab tests; X-rays and other radiology services; Necessary surgical and medical supplies; Use of appliances, such as wheelchairs; Operating and recovery room costs; Rehabilitation services, e.g., physical or occupational therapy and speech pathology services; Transplants (kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal), under certain conditions; Blood; Physician Services	List days covered, restrictions such as benefit period, and Copays/Coinsurance.

Covered Services	What You Pay for Covered Services
Inpatient Mental Health Care	List days covered, restrictions such as 190-day lifetime limit for inpatient services in a psychiatric hospital, Copays/ Coinsurance. [Note: The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.]
Inpatient Services (when the inpatient stay itself is not or is no longer covered): For more information, please see *Section 7.* - Physician services; - Diagnostic tests (like X-ray or lab tests); - X-ray, radium, and isotope therapy including technician materials and services; - Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations; - Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices; - Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition - Physical therapy, speech therapy, and occupational therapy; - Ambulance services	List Copays/Coinsurance

Covered Services	What You Pay for Covered Services
Skilled Nursing Facility Care *For more information, please see Section 7.* Semiprivate room (private if medically necessary); Meals including special diets; Regular nursing services; Physical, occupational and speech therapy; Drugs and biologicals; Blood; Medical and surgical supplies; Laboratory test(s); X-rays and other radiology services; Use of appliances such as wheelchairs Physician Services	List days covered, restrictions such as benefit period, Copays/Coinsurance, and whether any prior Hospital stay is required.
Home Health Care For more information, please see *Section 7.* <u>Home Health Agency Care:</u> Part-time or intermittent skilled nursing and home health aide services. Physical, occupational and speech therapy Medical social services Medical supplies <u>Also:</u> Physician Services Durable Medical Equipment Portable X-rays and EKGs Laboratory Tests	List Copays/Coinsurance
Hospice Care For more information, please see *Section 7.* Pain relief, symptom management, and support services for the terminally ill. Home care is provided. Also covers inpatient respite care and a variety of services usually not covered by Original Medicare.	Hospice services in a Medicare-participating Hospice are reimbursed directly by Medicare when you enroll in a Medicare-certified Hospice.

Covered Services	What You Pay for Covered Services
Outpatient Physician Services Office Visits including medical and surgical care in a physician's office or certified ambulatory surgical center; Consultation, diagnosis and treatment by a Specialist; Second opinion by another plan provider prior to surgery; Outpatient Hospital services; Dental Care; Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a doctor. *Also list any additional benefits offered.*	List Copays/Coinsurance.
Chiropractic Services Manual manipulation of the spine to correct subluxation. *Also list any additional benefits offered.*	List Copays/Coinsurance.
Podiatry Services Treatment of injuries and diseases of the feet. Foot care for certain medical conditions affecting the lower limbs. *Also list any additional benefits offered.*	List Copays/Coinsurance
Outpatient Mental Health Care (incl. Partial Hospitalization Services)	List Copays/Coinsurance
Outpatient Substance Abuse Services	List Copays/Coinsurance
Outpatient Surgical Services	List Copays/Coinsurance
Ambulance Transportation - Including air, water, or ground transport	List Copays/Coinsurance
Emergency Services- For more information, please see *Section 4.* Covered inpatient or outpatient services that are 1) furnished by a provider qualified to furnish emergency services; and 2) Needed to evaluate or stabilize an emergency medical condition.	List Copays/Coinsurance
Urgently Needed Services For more information, please see *Section 4.*	List Copays/Coinsurance
Outpatient Rehabilitation Services (Physical and Occupational Therapy and Speech and Language Therapy) Including Comprehensive Outpatient Rehabilitation Facility Services	List Copays/Coinsurance
Durable Medical Equipment and Related Supplies – Such as crutches, hospital bed, glucose monitor, IV infusion pump, oxygen equipment, nebulizer, and walker.	List Copays/Coinsurance

Covered Services	What You Pay for Covered Services
Prosthetic Devices - such as corrective lenses needed after a cataract operation, artificial limbs, ostomy bags, and certain related supplies and breast prostheses (including a surgical brassiere after a mastectomy). Includes replacement of artificial limbs or parts.	List Copays/Coinsurance
Diabetes Monitoring For all people who have diabetes (insulin and non-insulin users). Includes coverage for glucose monitors, test strips, lancets, and self-management training. *Also list any additional benefits offered.*	List Copays/Coinsurance.
Medical Nutrition Therapy (for people with diabetes or renal disease).	List Copays/Coinsurance
Blood (including Storage and Administration)	List Copays/Coinsurance.
Outpatient Diagnostic and Therapeutic Services and Supplies X-rays; Outpatient radiation therapy; Renal dialysis services (incl. Renal dialysis services when temporarily out of area); Surgical Supplies, such as dressings; Supplies, such as splints and casts; Therapeutic shoes for those with diabetic foot disease; Diagnostic Hearing Examinations; and Laboratory tests	List Copays/Coinsurance
Bone Mass Measurements For those at risk, Medicare covers procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. *Also list any additional benefits offered.*	List Copays/Coinsurance

Covered Services	What You Pay for Covered Services
Colorectal Screening Flexible sigmoidoscopy every 48 months, 50 and over. For individuals at high risk, screening colonoscopy every 24 months. For individuals not at high risk, screening colonoscopy every 10 years or within 48 months of a screening flexible sigmoidoscopy. Screening barium enema covered as an alternative to either a screening sigmoidoscopy or a screening colonoscopy, same frequency parameters apply. For individuals not at high risk of colorectal cancer – screening barium enema covered every 4 years. Fecal occult blood test, every 12 months for individuals age 50 and over. *Also list any additional benefits offered.*	List Copays/Coinsurance.
Preventive Care Services <u>Mammography Screening:</u> Screening for women age 40 and over every 12 months. Baseline exam for women age 35 to 39 years of age. <u>Pap Tests:</u> Once every 24 months, every 12 months if high risk. <u>Prostate Cancer Screening(For men age 50 and older):</u> Digital Rectal Exam – Once every 12 months. Prostate Specific Antigen (PSA) Test - Once every 12 months. <u>Immunizations:</u> Pneumococcal pneumonia vaccine Flu shots Hepatitis B vaccine (if at risk of contracting the disease). Other vaccines for those at risk (e.g., anti-rabies vaccine for those possibly exposed to rabies). *Also list any additional benefits offered.*	List all Copays/Coinsurance. [Note: You MUST include note that the member may self refer for mammography screening, screening pap tests, flu shots, and pneumococcal shots.

Covered Services	What You Pay for Covered Services
Drugs and Biologicals For more information, see *Section 6.* Drugs and biologicals that usually are not self-administered; Drugs used with authorized durable medical equipment; Hemophilia Clotting factors; Immunosuppressive drugs for individuals who get a Medicare covered organ transplant (as long as the transplant was paid for by Medicare); Injectable drugs for the treatment of osteoporosis for the home-bound who cannot self-administer; Antigens; Certain oral anti-cancer drugs and anti-nausea drugs; and Self-administered erythropoietin (home dialysis patients). *Also list any additional benefits offered.*	For prescription drugs not covered by Medicare on plan approved list (formulary), you pay for each prescription refill: • $ [amount] for generic drugs for up to a [x] day supply • $ [amount] for brand-name drugs for up to a [x] day supply • $ [amount] for mail order drugs for up to a [x] day supply List any copays/coinsurance for Medicare covered drugs and biologicals *Also mention any multi-tier copayment structure.*
Dental Services Routine services	List Copays/Coinsurance if applicable.
Hearing Services Diagnostic hearing exams *Also list any additional benefits offered.*	List Copays/Coinsurance.
Vision Care Outpatient physician services for eye care; Glaucoma screening (for high risk individuals, individuals with family history of glaucoma or individuals with diabetes); Original Medicare will pay for one pair of eyeglasses or contact lenses after each cataract surgery with insertion of an intraocular lens. *Also list any additional benefits offered.*	List Copays/Coinsurance.
Routine Physical Exams	List Copays/Coinsurance.
Health Education Programs *[Programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets. Describe the nature of the programs here]*.	List Copays/Coinsurance if applicable.
Health Promotion Programs *[Programs designed to enrich the health & lifestyles of members include weight management, smoking cessation, fitness & stress management. Describe the nature of the programs here.]*	List Copays/Coinsurance if applicable.

How you can purchase extra benefits ("optional supplemental benefits")

[*Note: Complete this section if the M+CO offers optional supplemental benefits in the plan. Describe the optional supplemental benefits, plan rules, and procedures to be followed by members who elect the optional supplemental coverage*.]

There are non-Medicare covered benefits that you can get which are not included in your package of benefits. These non-Medicare covered benefits are called "**Optional Supplemental Benefits**." [*Insert if appropriate*: If you choose to have optional supplemental benefits, you may have to pay an additional premium.] Members of [*name of M+C Plan*] must voluntarily elect optional supplemental benefits in order to get them.

[Insert plan specific optional benefits, premiums, and rules. Insert plan specific procedures on how to elect optional supplemental coverage, including application process and effective dates]

[Insert plan specific procedures on how to discontinue optional supplemental coverage, including refund of premiums. Also insert any restrictions on members' re-applying for optional supplemental coverage (e.g., must wait until next annual enrollment period)]

*[Include notation that: "*The optional supplemental benefits included in this section are subject to the same appeals process as any other benefits.*"]*

SECTION 6 Using your coverage for prescription medicines

[Note to M+COs: If you do not cover prescription drugs (outside of those required by Medicare), you may exclude all but the last section, which discusses medications covered by Original Medicare.]

[Note to M+COs: if you use a vendor to administer your prescription drug benefit, then this must be explained here. If you would like members to contact the vendor instead of your Member Services about prescription drug-related questions, then insert the vendor's phone # (including TTY #) in all applicable places in this section.]

Coverage for outpatient prescription drugs

The *[name of M+C Plan*] prescription drug benefit is above and beyond the basic Original Medicare benefit. Original Medicare covers a limited number of prescription drugs, usually those that must be administered by a health professional. See Section 5 for more information on Original Medicare-covered drugs. Original Medicare-covered prescriptions do not apply toward your *[Annual/Quarterly]* prescription benefit maximum (discussed below).

[For an additional monthly plan premium], [name of M+C plan] offers a prescription drug benefit for covered outpatient prescription drugs when prescribed by a *[name of M+C Plan]* physician and filled at a plan pharmacy *[insert as appropriate: or by our mail order service]*.

You are eligible for our prescription drug benefit if you are a member of *[name M+C Plan] [and pay an additional monthly plan premium of $ x amount]*.

How does the prescription drug benefit work?

You must pay a *[coinsurance, deductible, copayment]* for each new or refilled prescription drug. Coverage is limited to $ *[insert annual maximum]* ($ xxx per calendar quarter) for outpatient prescription drugs. This is called your "benefit maximum." [*M+COs with a quarterly maximum insert the following sentence:* On January 1, April 1, July 1, and October 1 of the calendar year you will have a benefit of *[insert quarterly maximum]* available for coverage of prescription medication.]

Your prescription drug benefit allows you to get covered drugs through a *[two/three]*-tiered copayment structure. You *[are/ are not]* covered for prescription drugs that are not on the plan approved list (formulary) (see *"What is a Formulary?"* below.) If your physician prescribes a drug from *[name of M+C Plan's]* formulary, you will pay a $ [*insert amount*] copayment for generic drugs for up to a [insert amount] day supply or a $ *[insert amount]* copayment for brand-name drugs for up to a [insert amount] day supply. If your physician prescribes a drug that is not on the *[name of M+C Plan]* formulary, [*you pay a $ [insert amount] copayment for up to a [insert amount] day supply/you pay the full amount because only formulary medications are covered]*.

How do you fill your prescriptions?

Retail Pharmacies

You can fill your prescription at any of our participating pharmacies. Please call Member Services at *[1-800-xxx-xxxx - include TTY # - list hours of operation for both #s]* to obtain a list of participating pharmacies.

If you are refilling a prescription, whenever possible please call the pharmacy 24 hours in advance so that your prescription will be ready for you when you come to pick it up. If you are a new member and need to have an existing prescription refilled, call your plan provider so that you can arrange to have the prescription filled at a [*name of M+C plan*] pharmacy.

Mail order services

You may order up to a 90-day supply of "maintenance medications" by mail. A "maintenance medication" is a prescription drug used on an ongoing basis. When ordering by mail, your copayment will be [*Amount of copayment]* per prescription.

Call Member Services at the number on the front of this booklet for more information about ordering maintenance medications by mail. Mail order forms are available from Member Services.

What is a "formulary"?

[Note to M+COs: Please tailor this section depending on the category of formulary applicable to your M+C Plan: open, incentivized, or closed.]

[Name of M+C Plan] prescription drug benefit includes a drug formulary which is a list of preferred or recommended drugs that have been selected by *[name of M+C plan]* physicians and pharmacists based upon the safety, efficacy and cost of those drugs.

The *[name of M+C Plan]* formulary is a comprehensive list of medications used by *[name of M+C Plan]* physicians to guide their medication prescribing decisions. All of the medications on this list of drugs are reviewed and approved by *[name of M+C Plan]* providers for use by *[name of M+C Plan]* members. The formulary is reviewed and revised *[monthly / quarterly]* and is subject to change without advance notice throughout the year. The *[name of M+C Plan]* formulary includes FDA-approved brand name and generic drugs.

- A **generic drug** is a drug product that meets the approval of the FDA and is equivalent to a brand name product in terms of quality and performance but may differ in certain other characteristics (e.g., shape, flavor, or preservatives). By law, generic drug products must contain the identical amounts of the same active drug ingredient as the brand name product. *[Name of M+C Plan]* pharmacies dispense generic drugs whenever possible.

You may use the *[name of M+C Plan]* grievance process (as described in Section 10) if you have complaints about which drugs are or are not included in the formulary, or about the administration of the formulary.

[Note to M+COs: include the following section if applicable.]

If your *[name of M+C Plan]* provider determines that you need a medication not on [*name of M+C Plan]* formulary, your physician must obtain prior authorization from [*name of M+CO]*. Upon receipt of the request for prior approval, [*name of M+CO]* will either grant prior approval or deny the request. You have the right to appeal any denial made by [*name of M+CO*] using the appeals process described in Section 10.

How can you get a copy of the formulary?

You may obtain a copy of the *[name of M+C Plan]* formulary by calling Member Services at [*insert phone number and include TTY # for the hearing impaired—list hours of operation for both #'s.] [Insert if appropriate:* You may also go to the *[name of M+CO]* web site on the Internet at : *www*.....]

How does the benefit maximum work?

Your prescription drug benefit maximum is applied on a/an *[annual, quarterly]* basis. The benefit maximum terminates at the end of December of each year, regardless of when your membership becomes effective. You *[can/cannot]* carry over unused prescription drug benefits from one *[quarter/month/year]* to the next.

[M+CO should provide an example here of how benefits for drugs are calculated:]

Example: (Using the Plan copayments of $ xx/xx/xx, and the annual prescription benefit Maximum of $ xxxx.) Beginning Balance: You start with an annual prescription benefit Maximum of $ xxxx.)

> **Step 1**: You have a prescription for a brand-name medication on the *[name of M+C Plan]* formulary filled at a *[name of M+C Plan]* pharmacy.
>
> **Step 2:** You pay your formulary brand-name medication copayment of $ *[insert amount*] to the pharmacy.
>
> **Step 3**: *[The average wholesale / retail] [price/cost]* of the prescription is $ *[insert amount]*.
>
> **Step 4:** *[The average wholesale price/cost is the standardized, published industry price for any given medication. / The retail price is the cost of the prescription that an individual pharmacy chooses to charge at the time of sale.]* In this example, it is $ *[insert amount]*. This is the amount deducted from your prescription fund benefit *(minus your copayment)* of $ *[insert annual amount*]. Your new existing balance is $ *[insert existing amount]*.

How do you check your fund balance?

To find out your *[Annual or Quarterly]* prescription fund balance, you may call Member Services [*M+COs insert the following phrase if they use a form:]* or send in an *[Annual or Quarterly]* prescription fund balance form.

Please have your *[name of M+C Plan]* Member ID number ready. If you have any questions, please contact Member Services at the number listed on the front of this booklet.

What happens if you reach the maximum?

If you exhaust your *[Annual/Quarterly]* prescription drug benefit maximum, you will have to pay for your prescription drug medication until the first day of the following calendar [*Year/Quarter*].

You may use the *[name of M+CO]* appeals process (as described in Section 10) if you disagree with us about your having met your drug benefit maximum. You may also use our grievance process (as described in Section 10) if have complaints about our administration of the drug benefit maximum.

Medications covered by Original Medicare

Receipt of these covered medications does not count against your *[insert amount] [Annual or Quarterly]* prescription limit:
[M+COs that do not have a prescription drug benefit should use the following sentence instead of the above sentence: The following medications are covered by Original Medicare:]

- Medications administered to *[name of M+C Plan]* members as part of a covered hospital or a covered skilled nursing facility stay.
- Medications and vaccines administered in *[name of M+C plan*] provider's office or hospital outpatient department as incident to a physician service.
- Immunosuppressive drugs following a covered transplant (as long as the transplant was paid for by Medicare), certain oral anti-cancer drugs and anti-nausea drugs, antigens, self-administered erythropoietin, and injectible drugs for the treatment of osteoporosis for the home confined who cannot self administer.
- Drugs used with authorized durable medical equipment.

Generally, medications you can buy without a prescription are not covered by *[name of M+C Plan]*.

SECTION 7 Using your coverage for hospital care, care in a Skilled Nursing Facility, and other services

Using your coverage for hospital care

If you need hospital care [*Name of M+CO*] will arrange covered services for you. By "hospital," we mean a Medicare-certified institution licensed by the State that provides inpatient, outpatient, diagnostic and therapeutic services. The term "hospital" does not include a convalescent nursing home, rest facility or facility for the aged that primarily provides custodial care, including training in routines of daily living.

[Note to M+CO: please include the following section if applicable.]
Hospital benefits are measured in terms of benefit periods. A benefit period is a period of consecutive days during which you get covered services, up to *[specify maximum amounts]*. As long as you continue to be entitled, there is no limit on the number of benefit periods you may have.

[Note to M+CO: If your plan uses physicians other than your member's PCP or the admitting specialist to oversee care while a member is hospitalized, you should provide a complete explanation of this practice here. This includes the use of "hospitalists," if applicable to your plan]

Note: If your *[name of M+C plan]* coverage began while you were an inpatient in a hospital, *[name of M+CO]* may not be responsible for the inpatient services until the date after your discharge. If we are not responsible for the inpatient services, either Original Medicare or the previous Medicare managed care plan you were enrolled is responsible for the inpatient hospital services. We have Member Services representatives available at *[1-800-xxx-xxxx - include TTY # for the "hearing impaired" - list hours of operation for both #s]* who can tell you if we would be responsible for your inpatient services.

[Name of M+C plan] is responsible for services, other than inpatient hospital services, beginning on your effective date of enrollment.

When your inpatient stay is not covered

If the inpatient stay itself is not covered, you may still be eligible for coverage of some services when arranged by [*Name of M+CO*] and furnished in a plan hospital or skilled nursing facility. These services are listed in the Schedule of Medical Benefits in Section 5.

Using your coverage for organ transplants

A Medicare approved transplant center determines whether you are a candidate for a transplant. Covered transplants are limited to corneal, heart, kidney, pancreas (when performed with or after a Medicare covered kidney transplant), liver, lung, heart-lung, bone marrow, intestinal and stem cell. Not all hospitals performing transplants are approved by Medicare. The following transplants must be performed in a Medicare approved transplant center in order to be covered by Medicare: heart, liver, lung, heart-lung, and intestinal.

Using your coverage for care in a Skilled Nursing Facility (SNF)

If you need skilled nursing facility (SNF) care [*Name of M+CO*] will arrange these services for you. Inpatient SNF coverage is limited to *[insert days, usually 100*] days each benefit period.

What is a "skilled nursing facility" or "SNF"?

A SNF is a facility (or distinct part of a facility) which is primarily engaged in providing its residents with skilled nursing or rehabilitation services and is certified by Medicare. The term "skilled nursing facility" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily "custodial care," including training in routines of daily living.

What is a "benefit period"?

A benefit period is used to determine Original Medicare coverage, and coverage under *[name of M+C Plan]*. A benefit period starts with the first day of your Medicare covered inpatient hospital stay and ends when you have been out of the hospital (or a SNF) for 60 days in a row.

Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital. However, for benefit period purposes you are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care criteria. This means that in order to have been an inpatient while in a SNF, you must have required skilled services on a daily basis and received daily skilled services that could, as a practical matter, only have been provided in a SNF on an inpatient basis. If any of these factors is not met then a stay in a SNF, even though it might include the delivery of some skilled services, is not covered.

Inpatient stays solely to provide custodial care are not covered

"Custodial care" is defined as care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by *[name of M+C Plan*] or Original Medicare unless provided in conjunction with daily skilled nursing care and/or skilled rehabilitation services.

What are "Home Care SNF" Services?

If you have been in the hospital and were in a SNF when you were admitted to the hospital, *[Name of M+CO]* will allow you to choose to return to a Home SNF for post-hospital extended care services upon discharge from the hospital. The term "Home SNF" means either:

- The SNF where you resided at the time you were admitted to the hospital;
- A SNF providing post-hospital extended care services through a continuing care retirement community that provided residence to you at the time you were admitted to the hospital; or
- The SNF in which your spouse is residing at the time you are discharged from the hospital.

There are some restrictions on which Home SNFs are covered by *[Name of M+CO]* (for example, the Home SNF must have a contract with us, or agree to accept payment under the terms that usually apply to SNFs that have contracts with us, and the Home SNF should be accessible and available to our geographic service area). Therefore, you will need to call us at *[insert phone number and department name (e.g., Care Management Department)]* when choosing a Home SNF to make sure we cover the services it provides.

Using your coverage for home health care

To qualify for home health benefits you must be confined to your home, be under a plan of treatment reviewed and approved by a physician, and require a medically necessary qualifying skilled service.

When you qualify for coverage of home health services, [*Name of M+C Plan*] covers either part-time or intermittent skilled nursing and home health aide services.

- "**Part-time**" means any number of days per week up to 35 hours per week of skilled nursing and home health aide services combined for less than 8 hours per day, based upon the need for and reasonableness of such additional care.
- "**Intermittent"** means either:
    - Up to 35 hours per week of skilled nursing and home health aide services. These services would be provided on a less than daily basis, based upon the need for and reasonableness of such additional care; or,
    - Up to and including full-time (i.e., 8 hours per day) skilled nursing and home health aide services. When needed, these services would be provided 7 days per week for temporary periods of time of up to 21 days. In exceptional circumstances, you can get extensions if you need more than 21 days.

You do not have to be bedridden to be considered confined to the home. However, your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment.

Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

Using your coverage for hospice care *(care for people who are near death)*

You may receive care from any Medicare-certified hospice. A "hospice" is an organization or agency that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families. As a *[name of M+C Plan]* member, you have the right to get information about all available Medicare-certified hospice providers. Please call Member Services at the number on the cover of this booklet to get this information.

- When you enroll in a Medicare-certified hospice, the hospice is reimbursed directly by Original Medicare for all the hospice services you receive;
- If you wish to elect Medicare-certified hospice services, we will give you a list of area Medicare-certified hospice providers;
- You may use a plan provider as your hospice attending physician if you and he or she so arrange;
- You may remain enrolled in *[name of M+C Plan]* even if you elect Medicare-certified hospice coverage for your terminal condition. Your care unrelated to the terminal condition can still be delivered by *[name of M+C Plan*].

NOTE: If you are enrolled in Part B only and not entitled to Part A, you should call us to get information on your hospice coverage.

Using your coverage for clinical trials

Routine costs of qualifying clinical trials are covered under *[name of M+C plan]*. When you enroll in a clinical trial, the providers are paid by us for all the covered services you receive. The clinical trial providers do not have to be *[name of M+C Plan]* providers. You will be responsible for any coinsurance or copayments for clinical trial services.

You do not need to get a referral to join a qualifying clinical trial. However, you should tell us before you start a clinical trial. That way, we can let you know whether it is a qualifying clinical trial covered by Medicare, and we can keep track of your health care services. When you tell us about starting a clinical trial we can let you know what services you will receive through clinical trial providers and

what coinsurance and copayments will be your responsibility. You may remain enrolled in *[name of M+C Plan]* even if you participate in a clinical trial. Your care unrelated to the clinical trial can still be delivered by *[name of M+C Plan]*.

Using your coverage for care in Religious Nonmedical Health Care Institutions

Services in a Medicare certified Religious Nonmedical Health Care Institutions (RNHCIs) are covered under *[name of M+C Plan]*. However, as with most services from specialists, you will need authorization for care in a RNHCI. Religious aspects of care provided in RNHCIs are not covered.

In order to be eligible for care in a RNHCI, an individual must have a condition that would allow them to receive inpatient hospital or extended care services. In addition, the individual must make an election that they are conscientiously opposed to the acceptance of "nonexcepted" medical treatment. "Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, State or local law. "Nonexcepted" medical treatment is any other medical care or treatment.

Section 8 Medical care and services that are **NOT** covered (list of exclusions)

An "**exclusion" is an item or service** that *[name of M+C Plan]* does not cover. You are responsible for paying for excluded items or services.

Any service (except for an emergency service or urgently needed service) that is not provided or arranged by a plan provider or not prior authorized is not covered by *[name of M+C Plan]* or by Medicare.

In addition to any exclusions or limitations described in the Schedule of Medical Benefits (in Section 5), the following items and services are limited or not covered by *[name of M+C Plan*]:

[NOTE: The following services are excluded from the Original Medicare benefit package. If any services below are covered as additional or supplemental benefits, they should be deleted from the list below.]

[NOTE: Since Original Medicare does not cover prescription medications that are usually self-administered, this first exclusion listed below is provided in the event that you offer an outpatient prescription drug benefit, but do not cover these particular types of medication].

- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.
- Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by *[name of M+CO*] or Medicare.
- Acupuncture
- Cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast reconstruction is covered when following a medically necessary mastectomy.
- Custodial Care, which includes care that helps members in the activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom; preparation of special diets; and supervision of medication that is usually self-administered.
- Homemaker services.
- Hospice services in a Medicare-participating hospice are not paid for by *[name of M+CO]*, but

reimbursed directly by Original Medicare when you enroll in a Medicare-certified hospice.

- Meals delivered to your home.
- Naturopaths' services.
- Nursing care on a full-time basis in your home.
- Orthopedic shoes unless they are part of a leg brace and are included in the orthopedist's charge, except *[name of M+C plan]* will cover therapeutic shoes for those suffering from diabetic foot disease as outlined in the schedule of medical benefits for "Outpatient Medical Services."
- Supportive devices for the feet, except *[name of M+C plan*] will cover orthopedic or therapeutic shoes as described above.
- Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
- Private duty nurses.
- Private room in a hospital, unless medically necessary.
- Charges imposed by immediate relatives or members of your household.
- Services that are not reasonable and necessary under Original Medicare program standards.
- Reversal of sterilization procedures; sex change operations; and non-prescription contraceptive supplies and devices. However, medically necessary services for infertility are covered.
- Emergency facility services for non-authorized, routine conditions that do not appear to a prudent layperson to be based on an emergency medical condition.
- Surgical treatment of morbid obesity unless determined medically necessary by a *[name of M+CO]* Medical Director or designee.
- Radial keratotomy and low vision aids and services.
- Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by *[name of M+CO]* and Original Medicare not to be generally accepted by the medical community. When deciding if a service or item is experimental, *[name of M+CO]* will follow Medicare's manuals or will follow decisions already made by Medicare
- Dental and routine foot care are generally not covered under the plan or are limited according to Medicare guidelines. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine, as outlined in Section 5) or is limited according to Medicare guidelines. (*Insert as appropriate:* However, these items are available under

Optional Supplemental Benefits. See Section 5 for a discussion on purchasing Optional Supplemental Benefits.)

*[**NOTE to Health Plan:** If your health plan has received a specific waiver from CMS for coverage of the limited abortion services covered by Original Medicare, you are required to provide the following disclaimer. You are also required to list the specific services you will not provide and an alternative method (telephone number) for obtaining information on the covered services that you will not provide based on moral or religious grounds. Please contact your the CMS Central Office Plan Manager for additional information]*.

- Counseling or referral services which *[Name of M+CO]* objects to based on moral or religious grounds. The law requires us to inform both current and prospective enrollees of specific counseling and referral services that are normally part of the Medicare benefit package, but which we do not provide due to objections based on moral or religious grounds. In the case of *[name of M+CO]* we will not provide counseling or referral services related to *[enter the benefits for which you will not provide counseling or referral services, e.g., advance directives related to withholding nutrition/treatment, etc.]*. To the extent these services are covered by Medicare, they will be covered under Original Medicare.

SECTION 9 What you must pay for your Medicare health plan coverage and for the care your receive (paying the plan premium for your membership in *[name of M+C plan]*, paying for Medicare Part A and Part B, paying your share of the cost when you receive care (such as copayments or other charges for office visits, prescriptions, hospital stays, etc.), what happens when you have other insurance)

Introduction: a summary list of your financial obligations

The list below is a summary of your financial responsibilities as a member of *[name of M+C plan]*. Each item in this list is explained in this section.

As a member of *[name of M+C Plan]*, you must:

1. Pay any applicable plan premium (see details below under "Paying the premium for your health plan coverage as a member of *[M+C plan name]*")
2. *[M+COs insert if appropriate:]* Pay your plan deductible (see details below under "Deductibles, copayments and other charges you must pay when you receive care and services")
3. Pay any applicable copayments or coinsurance (see details below under "Deductibles, copayments and other charges you must pay when you receive care and services")
4. Continue to pay your Medicare Part B premium (see details below under "Paying for Medicare Part A and Part B")
5. *[M+COs insert this section as appropriate]* If you have purchased an "Equivalent Part A Benefit" from us in the past, you must continue to pay this amount to continue your coverage (see "Paying for Medicare Part A and Part B" below)
6. Pay for services not covered by Original Medicare or *[name of M+CO]* (see "You must pay for services that are not covered by Original Medicare or [*name of M+CO*]" below)
7. Pay for services you receive after a benefit such as a prescription drug benefit has been used up (see details below under "You must pay for services that are not covered by Original Medicare or *[name of M+CO]*.
8. Keep *[name of M+CO]* up-to-date about other health insurance coverage you have, so that we can "coordinate your benefits" (see "What if you have other health insurance coverage besides *[name of M+C plan]*?" below)

Paying the premium for your health plan coverage as a member of [Name of M+C plan]

How much is the plan premium and how do you pay it?

In *[name of M+C Plan]*, you must pay a $___ premium each month. You must also continue to pay your Medicare Part B premium. *[M+COs: For $0 premium plan, delete 1st sentence and delete "also continue to" in 2nd sentence]*

As a *[name of M+C Plan]* member, you have *[two]* options for paying your monthly plan premium, or any other premiums that may be associated with optional supplemental benefits *[insert as appropriate: or your [M+C Plan] Part A Equivalent Benefit Premium]*. These are the *[provide names of programs]*. If you are interested in the *[option name], [insert directions for each option]*.

If you have any questions regarding your plan premium payment choices, please call *[Insert phone number include TTY # - list hours of operation for both #s]*

[Add any additional specific information, such as mailing of new coupon books, timing of payments, e.g., date due, consequences of not paying on time, etc.]

What happens if you don't pay your plan premiums or don't pay them on time?

[Note: M+COs that do not take action (i.e., to not downgrade or disenroll) against members who fail to pay basic and optional supplemental premiums do not need to include this section.]

[M+COs that elect to discontinue offering optional supplemental benefits for members who fail to pay the premium for these benefits, insert the following]: If you chose to add extra benefits (also known as "optional supplemental benefits") to your basic coverage in *[name of M+C plan]* and you do not pay your past-due plan premiums within a 90-day grace period, we will no longer cover the extra benefits. We will tell you in writing when that grace period begins if you have not paid your plan premiums.

[M+COs that elect to disenroll members who fail to pay plan premiums, insert the following]: We will disenroll you from *[name of M+C plan]* if you do not pay your plan premiums within the 90-day grace period. You will then have Original Medicare coverage. We will tell you in writing when that grace period begins if you have not paid your plan premiums. *[Insert if applicable to the plan: Should you decide later to re-enroll in the plan or to enroll in another plan offered by [name of M+CO], you must pay any premiums due from your previous enrollment in the plan.]*

Can the plan premium change?

Between January 1, 2002 and December 31, 2002, we are allowed to decrease your plan premium, but

we cannot increase it. Increases in your plan premium are only allowed at the beginning of each calendar year, and must be approved by the Medicare program. We will let you know in October 2002 if there will be any changes in your premiums or what you have to pay beginning January 1, 2003. We will also let you know in writing if we plan to decrease your plan premium in 2002.

Paying for Medicare Part A and Part B

- Medicare Part A Premium -- Most people do not have to pay a monthly premium to cover Medicare Hospital Insurance (Part A) because they or their spouse paid Medicare taxes while they were working. If you have to pay for Part A, you must continue to pay your Medicare Part A premium. If you would like to purchase Part A, please call your local Social Security Office or call 1-800 772-1213 toll free. The TTY number for Social Security is 1-800 325-0778.
- *Insert as appropriate:* [*Name of M+C Plan]* Part A "Equivalent" Benefit Premium -- This premium only applies to you if your membership with us started prior to January 1, 1999. The monthly premium for the *[name of M+C Plan*] Part A Equivalent Benefit Premium is $___.
- Medicare Part B Premium – This is a monthly premium paid to Medicare to cover Supplemental Medical Insurance (Part B). If you receive Social Security benefits, this premium is usually taken out of your benefits. Otherwise your premium is paid directly to Medicare by you or by someone on your behalf (such as your State Medicaid agency).

Copayments, and other charges you must pay when you get care

What are "deductibles," "copayments," and "co-insurance"? [M+COs – delete "deductibles" if plan does not have a deductible]

- *[M+COs – insert if applicable]* Deductible – The amount you must pay for health care, before *[name of M+C Plan]* begins to pay.
- Copayment -- The amount that you pay for each medical service you get, such as a doctor visit. It is a set amount per visit. All copayments should be paid at the time of service.
- *[M+COs – insert if applicable]* Coinsurance – A percentage of the cost of the service that you have to pay.

You must pay for all care and services that are not covered by Original Medicare or *[Name of M+CO]*.

You are personally responsible for paying for care and services that are not covered by Original Medicare or *[name of M+CO]*. With just a few exceptions, you must pay for services you receive from providers who are not part of *[name of M+C plan]* unless *[name of M+CO]* has approved these services in advance. The exceptions are emergency services, urgently needed services, and out-of-area

renal dialysis services. Also, you must pay for services you receive after a benefit has been used up, such as paying for prescription drugs after you use *[name of M+C plan]*'s *[quarterly/annual]* maximum allowed.

What happens if you have other insurance?

You must use other insurance coverage if you have it

If you have other health insurance in addition to coverage with *[name of M+C plan]*, you may need to use this other insurance coverage in combination with your coverage as a member of *[name of M+C plan]* to pay for the care you receive. This is called "coordination of benefits" because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Please keep us up to date on any additional insurance you have

You must tell us if you have any other health insurance coverage besides [*name of M+C plan*], and let us know whenever there are any *changes* in your additional insurance coverage. These types of additional insurance you might have include the following:

- Coverage that you have from an employer's group health insurance for *employees* or *retirees*, either through yourself or your spouse
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program
- Coverage you have for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through Medicaid or through the "Tricare for Life" program (veteran's benefits)
- Coverage you have for dental insurance or prescription drugs
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions)

Who pays first when you have additional insurance?

If you have additional insurance coverage, how we coordinate your benefits as a member of *[name of M+C plan]* with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through *[name of M+C plan]*, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by *[name of M+C plan],* you may get your care outside of *[name of M+C plan]*.

In general, the insurance company that pays its share of your bills *first* is called the "**primary payer**." Then the other company or companies that are involved -- called the "**secondary payers**" -- each pay

their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with *[name of M+CO]* and you will not have to be involved. However, if payment owed to *[name of M+CO]* is sent directly to you, you are required under Medicare law to give this payment to *[name of M+CO]*.

When you have additional health insurance, **whether we pay first or second --or at all-- depends on what type or types of additional insurance you have and the rules that apply to your situation**. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer's group insurance.

If you have additional health insurance, please call Member Services at the phone number on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First (publication number 02179).* You can get a copy by calling 1-800-MEDICARE, or by visiting the www.medicare.gov website.

How we pay the doctors and other providers who take care of you

In order to get quality service in an efficient manner, [*name of M+CO]* pays its providers using various payment methods, including *[M+CO insert as appropriate: capitation, per diem, incentive and discounted fee-for-service arrangements.]*

- Capitation means paying a fixed dollar amount per month for each member assigned to the provider.
- Per diem means paying a fixed dollar amount per day for all services rendered.
- Incentive means a payment that is based on appropriate medical management by the provider.
- Discounted fee-for-service means paying the provider's usual, customary and regular fee discounted by an agreed-to percentage.

You have the right to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services that you might need. To get this information, call Member Services at the number on the cover of this booklet and ask for information about our physician payment arrangements.

Note that it is [*name of M+CO's*] responsibility to pay provider charges for the covered benefits and services you receive (other than the copayments, coinsurance, or other payments that are your responsibility). This includes paying plan providers (those that are part of *[name of M+C plan]*), and paying non-plan providers who have been authorized by us to provide services to you, or who provide covered emergency, post-emergency, urgently needed services, or out-of-area dialysis. In the event we

fail to pay provider charges for covered services or prior authorized services, you will not be liable for any payment owed by [*name of M+CO]*.

What if you pay or are billed for services you believe we should pay for?

If you *pay for* covered emergency, urgently needed, or out-of-area renal dialysis services which you receive from a non-plan provider, please send your bill to us at the following address and we will reimburse you for the covered amount: *[M+CO: Insert name, address]*.

If you *receive a bill* from any non-plan provider, please do not pay it. Instead, please send it to us at this same address above; we will pay for the covered amount.

SECTION 10 Appeals and grievances: what to do if you have concerns or complaints (how to handle problems related to your coverage, including payment for your care; problems about hospital discharge; and other types of problems)

We encourage you to let us know right away if you have questions, concerns, or problems with any part of your coverage. Please call Member Services at the number on the cover of this booklet.

This section explains what you can do to deal with any problems you may have. It gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a member of [*name of M+C Plan*]. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. You cannot be dropped from [*name of M+C plan*] or penalized in any way if you make a complaint.

In this section, **we use the word "complaint" in a general way to mean an action you can take to deal with a problem**. There are different rules for making complaints depending on the type of problem you are having. This section has separate parts that give the rules for each of the following situations:

- **Complaints related to your coverage, including payment for your care**. This includes whether a particular treatment or other care you want is covered by [*name of M+C plan*]. It also includes whether [*name of M+CO*] will pay for care you have received that you think is covered by [*name of M+C plan*].
- **Complaints about being discharged from the hospital too soon**
- **Complaints ("grievances") about *all other* types of problems**

As you will see later in this section, a complaint that asks for a decision about coverage or payment for care to be reconsidered is called an "**appeal**" or a "request for reconsideration." A complaint about quality of care is called a "**grievance**" (complaints about quality of care fall under the category of "complaints about all other types of problems").

Complaints related to your coverage, including payment for care

This part of Section 10 explains what you can do if you have problems getting the medical care you believe that we should provide. We use the word "provide" in a general way to include such things as authorizing care, paying for it, arranging for someone to provide it, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by [*name of*

M+C plan]

- If [*name of M+CO*] will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by [*name of M+CO*]
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health
- If you have received care that you believe is covered by [*name of M+C plan*], while you were a member of [*name of M+C plan*], but we have refused to pay for this care

Six possible steps for requesting care or payment from [*name of M+C Plan*]

If you are having a problem getting care or payment for care, there are six possible steps you can take to request the care or payment you want from [*name of M+CO*]. At each step, your request is considered and a decision is made. If you are unhappy with the decision, there may be another step you can take if you want to continue requesting the care or payment.

- In Steps 1 and 2, you make your request directly to [*name of M+CO*]. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to [*name of M+CO*] make the decisions about your request. To keep the review independent and impartial, those who conduct the review and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The six possible steps are summarized below. **These same six steps are covered in more detail in Appendix B at the end of this booklet**.

STEP 1: The initial decision by [name of M+CO]

The starting point is when [*name of M+CO*] makes an "initial decision" (also called an "organizational decision") about your medical care or about paying for care you have already received. When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of [*name of M+C plan*] apply to your specific situation. As explained in Appendix B, you can ask for a "fast initial decision" if you have a request for medical care that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by [name of M+CO]

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**appeal**" or a "request for reconsideration." As explained in Appendix B, you can ask for a "fast appeal" if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want.

STEP 3: Review of your request by an Independent Review Organization

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of [*name of M+CO*]. This organization will review your request and make a decision about whether we must give you the care or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least $100 to be considered in Step 4.

STEP 5: Review by a Departmental Appeals Board

If you or [*name of M+CO*] are unhappy with the decision made in Step 4, you or [*name of M+CO*] may be able to ask a **Departmental Appeals Board** to review your case**.** This Board is part of the federal department that runs Medicare.

STEP 6: Federal Court

If you or [*name of M+CO*] are unhappy with the decision made by the Departmental Appeals Board in Step 5, either you or [*name of M+CO*] may be able to take your case to a Federal Court. The dollar value of your medical care must be at least $1,000 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, please see Appendix B at the end of this booklet.

What to do if you think coverage of your hospital stay is ending too soon

When you are hospitalized, you have the right to get all the hospital care covered by *[name of M+C plan]* that is necessary to diagnose and treat your illness or injury. According to Federal law, the date you leave the hospital (your "**discharge date**") must be determined solely by your medical needs. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should show you a notice called the *Important Message from Medicare*. This notice explains your rights under the law.

When a doctor decides that you are ready to leave the hospital (to "be discharged"), you should be given a copy of the notice that includes specific information about your hospital discharge. It will tell you:

- Why you are being discharged

- Your discharge date, which is the date we will stop covering your hospital stay (stop paying your hospital costs)
- What you can do if you think you are being discharged too soon

As a member of [*name of M+C plan]*, you should receive this information about your discharge *before* you leave the hospital. You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not receive the notice when you are being told about your discharge from the hospital, be sure to ask for it immediately.

Review of your hospital discharge by the Peer Review Organization (the PRO)

If you think that you are being discharged too soon, you have the right by law to ask for a review of your discharge date. As explained in the *Important Message from Medicare,* if you act quickly, you can ask an outside agency called the PRO to review whether your discharge is medically appropriate.

What is the PRO?

"PRO" stands for Peer Review Organization. The PRO is a group of health care professionals who are paid by the Federal Government. They are not part of *[name of M+CO]* or your hospital. There is one PRO in each state. The name of the PRO differs depending on which state you are in. See Section 1, *Telephone numbers and other information for reference*, for more about the PRO.

Getting a PRO review of your hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the PRO. The *Important Message from Medicare* gives the name and telephone number of your PRO and tells you what you must do:

- You must ask the PRO for a **"fast review"** of whether you are ready to leave the hospital. This "fast review" is also called a "fast appeal" because you are appealing the discharge date that has been set for you.
- You must be sure that you have made your request to the PRO **no later than noon** on the date you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from the PRO (see below).

If the PRO reviews your discharge, it will examine your medical information then give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The PRO will make this decision within one day after it has received all of the medical information it needs to make a decision.

- If the PRO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon the day after the PRO gives you its decision.
- If the PRO agrees with you, then *[name of M+CO*] will continue to cover your hospital stay for as long as medically necessary while you are a member of *[name of M+C plan*].

What if you do not ask the PRO for a review by the deadline?

You may have to pay if you stay past your discharge date

If you do *not* ask the PRO by noon on the date you are given written notice that you are being discharged from the hospital, **and if** you stay in the hospital after this date, you run the risk of having to pay for the hospital care you receive on and after this date. However, you can appeal any bills for hospital care you receive, using Step 1 of the appeals process described in Appendix B.

You still have another option: asking [name of M+CO] for a "fast appeal" of your discharge

If you do not ask the PRO to do a "fast review" ("fast appeal") of your discharge, you can ask us for a "fast appeal" of your discharge. How to ask [*name of M+CO*] for a fast appeal is covered briefly in the first part of this section and in more detail in Appendix B.

If you ask [*name of M+CO*] for a fast appeal of your discharge and you stay in the hospital past your discharge date, you run the risk of having to pay for the hospital care you received past your discharge date. Whether you have to pay or not depends on the decision we make:

- If we decide, based on the fast appeal, that you need to stay in the hospital, [*name of M+CO*] will continue to cover your hospital care for as long as medically necessary.
- However, if we decide that you should not have stayed in the hospital beyond your discharge date, then [*name of M+CO*] will **not** cover any hospital care you receive if you stayed in the hospital after the discharge date.

Making complaints ("filing grievances") about all other *types of problems*

This last part of Section 10 explains how to make complaints about any *other* type of problem that has not already been discussed earlier in this section. (The problems that have already been discussed are problems related to coverage or payment for care, and problems about being discharged from the hospital too soon.)

What is included in "all other types of problems"?

Here are some examples of problems that are included in this category of "all other types of problems":

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay

- If you believe that mistakes have been made
- If you feel that you are being encouraged to leave (disenroll from) [*name of M+C plan]*
- If you feel that you are being discouraged from seeking the care you think you need
- Problems with the customer service you receive
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room
- Problems with getting appointments when you need them, or having to wait a long time for an appointment
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff
- Cleanliness or condition of doctor's offices, clinics, or hospitals

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance."

Filing a grievance with [*name of M+C plan*]

If you have a complaint, we encourage you to first call Member Services at the number on the front of this booklet. We will try to resolve any complaint that you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this [*insert name of M+CO's grievance procedure]*. [*Insert description of the procedures and instructions about what members need to do if they want to use it*]

For quality of care problems, you may also complain to an outside agency called the PRO

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to an independent organization called the PRO. "**PRO"** stands for Peer Review Organization. The PRO is a group of doctors and other health care professionals who are paid by the Federal Government. They are not connected to [*name of M+CO*] or your hospital. There is one PRO in each state. The actual name of the PRO differs depending on which state you are in. See Section 1, *Telephone numbers and other information for reference,* for more about the PRO.

SECTION 11 Disenrollment: leaving *[name of M+C plan]* and your choices for continuing Medicare after you leave

(including new rules about when and how often you can make changes, and what happens if you move or if [*name of M+C plan*] leaves Medicare)

What is "disenrollment"?

"Disenrollment" from [*name of M+C plan]* means **ending your membership** in [*name of M+CO]*. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave [*name of M+C plan]* because you have decided on your own that you *want* to leave. You can do this for any reason. However, as we explain in this section, **there is a new law that limits <u>when</u> you can leave and <u>how often</u> you can make changes.**
- There are also a few situations where you would be *required* to leave. For example, you would have to leave [*name of M+C plan]* if you move out of our geographic service area or if [*name of M+C plan]* leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving [*name of M+C plan]* is your choice or not, this section tells about your choices for continuing with Medicare after you leave and explains the rules that apply.

Until your membership officially ends, you must keep getting your routine care through [*name of M+C plan*] or you will have to pay for it yourself

If you leave [*name of M+C plan]*, it takes some time for your membership to end and your new way of getting Medicare to take effect (we'll discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member of [*name of M+C plan]* and must continue to get your routine care as usual through *[name of M+C plan]*.

If you get unauthorized services from doctors or other medical providers who are <u>not</u> plan providers before your membership in [*name of M+C plan]* ends, neither [*name of M+CO]* nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed services, emergency services, out-of-area dialysis services, and referrals that have been approved by [*name of M+CO]*. There is another possible exception if you happen to be hospitalized on the day your membership in *[name of M+C plan]* ends: if this happens to you, call Member Services at the number on the cover of this booklet to find out if your hospital care will be covered by [*name of M+C plan]*. If you have any questions about leaving [*name of M+C plan]*, please call us at Member Services.

What are your choices for continuing Medicare if you leave [*name of M+C plan]*?

If you leave *[name of M+C plan]*, you may have several choices for continuing Medicare. One choice is to go to **Original Medicare.** You may also have the choice of joining another **Medicare managed care plan** or a **Medicare Private Fee-for-Service plan** *if* any of these types of plans are available in your area and they are accepting new members.

- **Original Medicare** is available throughout the country. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
- **Medicare managed care plans** are available in some parts of the country. In Medicare managed care plans you go to the doctors, hospitals, and other providers *that are part of the plan*. These plans must cover all Medicare Part A and Part B health care. Most cover additional benefits, such as prescription drugs. [*Name of M+C Plan*] is a Medicare managed care plan offered by [*name of M+CO*].
- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to *any* doctor or hospital you want as long as the doctor or hospital agrees to accept the terms of the plan. The Private Fee-for-Service plan decides how much you pay for the services you get, so what you pay may differ from what you would pay if you had Original Medicare. You may get extra benefits that Original Medicare does not cover. Private Fee-for-Service plans are *not* the same as Medigap (Medicare supplement insurance).

To find out which Medicare managed care plans and Private Fee-for-Service plans are available in your area, you can call the national 1-800-MEDICARE help line. You can also use the "Medicare Personal Plan Finder" at www.medicare.gov on the web. The Medicare Personal Plan Finder is a tool that allows you to narrow down and compare your health plan choices based on what is most important to you. It gives you the ability to compare all your health insurance options and get a personalized page with more detailed information on the plans you select. You can also call your SHIP (which stands for State Health Insurance Assistance Program). *Section 1, Telephone numbers and other information for reference*, tells about the Medicare help line, the Medicare website, and the SHIPs (SHIPs have different names depending on the state you live in).

When **and** ***how often*** **can you switch among your Medicare choices?**

As explained above, there are three basic ways of getting Medicare coverage: Original Medicare (*available to all people with Medicare*), Medicare managed care plans (*available in some areas*), and Medicare Private Fee-for-Service plans (*available in some areas*). Depending on where you live, and

how many managed care plans and Private Fee-for-Service plans are available, these three ways to get Medicare may offer you a number of different choices.

A new law about when and how often you can switch

Starting in 2002, there is a new law that governs when and how often you can change the way you get Medicare by switching from one of your choices to another. Even if you just switch from one Medicare +Choice plan (like [*name of M+C plan*]) to one of the other Medicare +Choice plans we offer, it still counts as making a change.

Here are the new rules:

1. During the first six months of the year, between January 1, 2002 and June 30, 2002, everyone with Medicare (including members of [*name of M+C plan]*) is allowed to make *one change only* in the way they get Medicare coverage by switching from their current way of getting Medicare coverage to one of their other choices. (It does not count as a change when we must end your membership, as discussed later in this section.)

2. Later in the year, from November 1 through November 30, everyone with Medicare has an opportunity to switch from one way of getting Medicare to another. During November, people with Medicare are free to request any type of change from their current way of getting Medicare to one of their other choices. Requests for change that are made in November take effect on January 1.

3. Other than making one change in November, *no one* with Medicare is *allowed to make any changes* in the way they get Medicare during the last six months of the year (from July 1 through December 31) unless they meet one of the following exceptions:

   - *An exception that applies only to people who turn 65 during the year 2002*: If you turn 65 during the year 2002 and you join a Medicare +Choice plan (such as [*name of M+C plan]*) during 2002, you are allowed to make a one-time change from the plan *to Original Medicare* at any time during the 12-month period after the date that you join the plan.
   - *An exception that applies only to people who are in an institution*: If you are in a institution (like a skilled nursing facility or a rehabilitation hospital) at the time you leave *[name of M+C plan]*, you are allowed to leave our plan and go to Original Medicare, another Medicare managed care plan, or a Private Fee-for-Service plan.
   - *An exception that applies only to people who were first eligible to join a plan in 2002:* If you became a member of [*name of M+C plan*] in 2002 and it was the first time you were eligible to join a Medicare +Choice plan, you will be allowed to leave [*name of M+C plan*] to go to Original Medicare, another Medicare managed care plan, or a Private Fee-for-Service plan. However, you will only be allowed to leave [*name M+C plan*] under this exception if you leave within six months of the date you became eligible to join a Medicare +Choice plan and no later than December 31, 2002.

- *An exception for special circumstances*: Under certain conditions, you may be allowed to make a change regardless of the time of year and any previous changes you may have made. Please call Member Services at the number on the cover of this booklet if you need to know if you might be able to use one of these special circumstances to leave [*name of M+C plan*]. These conditions include:
  - moving out of the plan's geographic service area,
  - joining a plan offered by your employer,
  - being eligible for Medicaid,
  - being eligible for the Program of All-inclusive Care for the Elderly (PACE), or,
  - having special "guaranteed issue" rights to purchase a Medigap (Medicare supplement insurance) policy.

What should you do if you decide to leave *[name of M+C plan]*?

If you want to leave [*name of M+C plan]*:

- The first step is to **be sure that the type of change you want to make and the timing of this change fit with the new rules** that we just explained about changing from one of your Medicare choices to another. If you are not following these rules, you won't be allowed to make the change you request.
- Then, as we explain below, what you must do to leave [*name of M+C plan*] depends on whether you want to switch to Original Medicare or to one of your other choices.

How to change from *[name of M+C plan]* to Original Medicare

If you want to change from [*name of M+C plan*] to Original Medicare, and you are thinking about buying Medigap (Medicare supplement insurance) to supplement you Original Medicare coverage, you should first contact the SHIP in your state to learn if you have a guaranteed right to buy a Medigap policy even if you have health problems. You can find the phone number for the SHIP in Section 1.

When you decide to return to Original Medicare, you must tell us that you want to leave [*name of M+C plan*]. You do *not* have to notify Original Medicare, because you will automatically be in Original Medicare when you leave [*name of M+C plan*]. Here is how it works:

1. First, use any of the following ways to tell us that you want to leave [*name of M+C plan]:*
   - You can write a letter to us [*note to M+COs: mentioning the disenrollment form is optional*] or fill out a disenrollment form and send it to *[name of M+CO]* Member Services at [*insert address*]. Please make sure you sign and date your letter [form]. To get a disenrollment form, call us at [*insert phone number or if applicable say:* the Member

Services telephone number on the cover of this booklet.]

- You can call the national 1-800-MEDICARE help line. *Section 1, Telephone numbers and other information for reference,* tells you how to contact the helpline.
- You can contact your nearest Social Security office or, if you have Railroad Retirement benefits, you can contact the Railroad Retirement Board office. *Section 1, Telephone numbers and other information for reference*, tells you how to contact these offices.

2. After we learn about your request to leave the plan, we will send you a letter that tells you when your membership will end (provided that your request follows the new rules about making changes). This is your **disenrollment date** – the day you officially leave [*name of M+C plan]*. In most cases, your disenrollment date will be the first day of the month that comes after the month when we receive your request to leave [*name of M+C plan]*. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. There is an exception to this general rule about disenrollment dates: the disenrollment date for requests made in November will be January 1. Remember that while you are waiting for your membership to end, you are still a member of [*name of M+C plan]* and must continue to get your medical care as usual through [*name of M+C plan]*.
3. When your membership ends on your disenrollment date, you can start using your red, white, and blue Medicare card to get services under Original Medicare. (You can call Social Security at 1-800-772-1213 if you need a new card.) You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave [*name of M+C plan]*.

How to change from [*name of M+C plan]* to another Medicare managed care plan or to a Private Fee-for-Service Plan

When you have chosen a different Medicare managed care plan or a Private Fee-for-Service plan that you want to join, here is what to do (provided that the change you want to make follows the new rules about making changes):

1. Simply apply for membership in the new plan you want to be in. ***Please do not*** tell us in advance that you are changing from *[name of M+C plan]* to a different plan because **this might cause your enrollment in the new plan to be denied**. We do not need to know that you are leaving *[name of M+C plan]* if you enroll into another plan. Once you are enrolled in your new plan, your membership in [*name of M+C plan]* will *automatically* end.
2. Your new plan will tell you in writing that date when your membership in that plan begins, and your membership in [*name of M+C plan]* will end on that same day (this will be your "disenrollment date" from [*name of M+C plan]*). Remember that you are still a member of [*name of M+C plan]* until your disenrollment date, and must continue to get your medical care as usual through [*name of M+C plan]* until the date when your membership ends.

What happens to you if [*name of M+CO*] leaves the Medicare program or [*name of M+C plan*] leaves the area where you live?

If *we* leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. **If any of these things happen, you will be allowed to change to another way of getting Medicare**. Your choices will always include going to Original Medicare, and they may also include joining another Medicare managed care plan or a Private Fee-for-Service plan if such plans are available in your area and are accepting new members.

[Name of M+CO] has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either [*name of M+CO]* or CMS can decide to end it. It is also possible for our contract to end at some other time, too. If the contract is going to end, we will generally tell you at least 90 days in advance. Your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

Until we tell you in writing that you must leave [*name of M+C plan]* and give you a date when your membership stops, you will continue as a member of [*name of M+C plan]* and will continue to get your medical care in the usual way through [*name of M+C plan]*. All of the benefits and rules described in this booklet will continue until your membership ends.

What if you move out of *[name of M+C plan*]'s service area, or are away from the service area for long periods of time?

You must leave [*name of M+C plan]* if you move out of our service area or are away from our service area for more than six months in a row

If you plan to move or take a long trip, please call Member Services at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in *[name of M+C plan]*'s geographic service area. If you move permanently out of our service area, or if you are away from our service area for more than six months in a row, you will need to leave ("disenroll" from) *[name of M+C plan]*. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). An earlier part of this section tells about the choices you have if you leave *[name of M+C plan]* and explains how to leave.

Under certain conditions [*Name of M+CO]* can end your membership and make you leave the plan

As we explained above, we must end your membership and require you to leave the plan if you move permanently out of our geographic service area or live outside our service area for more than six

months at a time.

We cannot ask you to leave because of your health

[*Name of M+CO*] is allowed to ask you to leave the plan under certain special conditions that are described below. These conditions do *not* include asking you to leave because of your health: **no member of any Medicare health plan can be asked to leave the plan for any health-related reasons**.

If you ever feel that you are being encouraged or asked to leave [*name of M+C plan]* because of your health, you should call the national Medicare helpline at 1-800-MEDICARE help line. *Section 1, Telephone numbers and other information for reference,* tells you how to contact the helpline.

We *can* ask you to leave under certain special conditions

As we explained above, we must end your membership and require you to leave the plan if you move out of our geographic service area or live outside our service area for more than six months at a time. We must also end your membership and make you leave the plan under the following circumstances:

- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B.
- If you give [*name of M+CO]* information on your enrollment form that is false or deliberately misleading, and it affects whether or not you can enroll in *[name of M+C plan]*.
- If you behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects our ability to arrange or provide medical care for you or for others who are members of [*name of M+C plan]*. Before we can make you leave [*name of M+C plan]* for this reason, *we must get permission* from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your [*name of M+C plan]* membership card to get medical care. Before we ask you to leave [*name of M+C plan]* for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.
- *[NOTE to M+CO: Include the following only if applicable]* If you do not pay the plan premiums. We will tell you of a 90-day grace period during which you can pay the plan premiums before you are required to leave *[name of M+C plan]*.

You have the right to make a complaint if we ask you to leave *[name of M+CO]*

If we ask you to leave [*name of M+C plan]*, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to. *[Note to M+CO: If there are specific State requirements regarding involuntary disenrollment and/or if your members have other state-mandated rights regarding the grievance process, describe them here]*

APPENDIX

APPENDIX A. Reference list of important words used in this booklet

The following definitions apply to this Evidence of Coverage and Disclosure Information. *[Note: The M+CO may insert definitions not included in this model or exclude model definitions not applicable to the M+CO's contractual obligations with CMS or enrolled Medicare beneficiaries.]*

Appeal -- Any of the procedures that deal with the review of adverse initial decisions on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service. These procedures include reconsiderations by *[name of M+CO]*, review by an independent outside organization, hearings before Administrative Law Judges (of the Social Security Administration), review by the Departmental Appeals Board, and judicial review.

Benefit Period -- This is used to determine Original Medicare coverage, and coverage under *[name of M+C Plan]*. A benefit period starts with the first day of your Medicare covered inpatient hospital stay and ends when you have been out of the hospital (or a SNF) for 60 days in a row. Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital. The type of care actually received is not relevant. However, you are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. This means that in order to have been an inpatient while in a SNF, you must have required skilled services on a daily basis and received daily skilled services that could, as a practical matter, have only been provided in a SNF on an inpatient basis.

Calendar Year -- The period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Centers for Medicare & Medicaid Services (CMS) -- the Federal Agency that runs the Medicare program (formerly known as the Health Care Financing Administration).

Covered Services -- The medically necessary benefits, services and supplies listed in Section 5 of this booklet which are:

- Services provided or furnished by plan providers *[or "authorized by its plan providers"*].
- Emergency Services and Urgently Needed Services which may be provided by plan and non-plan providers. (Please refer to Section 4 for more information about emergency services and urgently needed services).

- Post-stabilization services furnished by non-plan providers or facilities that are authorized by us or were not pre-approved because *[name of M+CO]* did not respond to a request for pre-authorization for such services within 1 hour of the request (or because we could not be contacted for pre-authorization).

- Renal dialysis services provided while you are temporarily outside the service area.

Custodial Care -- Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by *[name of M+C Plan*] or Original Medicare unless provided with skilled nursing care and/or skilled rehabilitation services.

Disenroll or Disenrollment -- The process of ending your membership in *[name of M+C Plan]*. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment -- Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. However, an institution may not be considered a member's home if it meets the basic requirements of a hospital or skilled nursing facility. DME includes items such as oxygen equipment, wheelchairs, hospital beds and other items that are determined medically necessary, in accordance with Medicare law, regulations and guidelines.

Emergency Medical Condition -- A medical condition brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not getting immediate medical attention could result in 1) Serious jeopardy to the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child); 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Emergency Services -- Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage and Disclosure Information -- This document, along with your enrollment form *[insert if applicable any reference to attachments, riders or other optional coverage selected]*, which explains the covered services, defines our obligations, and explains your rights and responsibilities as a member of the *[name of M+C Plan*].

Exclusion -- Items or services that *[name of M+C Plan]* does not cover. You are responsible for paying for excluded items or services.

Experimental Procedures and Items -- Items and procedures determined by Medicare not to be generally accepted by the medical community. When deciding if a service or item is experimental,

[name of M+CO] will follow the Centers for Medicare & Medicaid Services' manuals or will follow decisions already made by Medicare. With the exception of procedures and items under approved clinical trials, experimental procedures and items are not covered under this Evidence of Coverage.

Grievance -- Any complaint or dispute other than one involving an "initial decision." Examples of issues that involve a complaint that will be resolved through the grievance rather than the appeal process include: waiting times in physician offices and rude or unresponsive Member Service staff.

Home Health Agency -- A Medicare-certified agency that provides skilled nursing care and other therapeutic services in your home when medically necessary.

Hospice – A Medicare-certified organization or agency that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital -- A Medicare-certified institution licensed by the State, that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "hospital" does not include a convalescent nursing home, rest facility or facility for the aged that primarily provides custodial care, including training in routines of daily living.

*[**NOTE:** You should use the following (or a similar) definition if your plan uses physicians other than your member's PCP or the admitting specialist to oversee care while a member is hospitalized. You should also include a complete explanation of this practice in Section 3 of this Model EOC.]*
Hospitalist – A physician who specializes in treating patients when they are in the hospital and who may coordinate a patient's care when he or she is admitted at a *[name of M+C Plan*] hospital.

Independent Practice Association (IPA) -- A partnership, association, or corporation that delivers or arranges for the delivery of health services and which has entered into a contract with health professionals, a majority of whom are licensed to practice medicine or osteopathy.

Initial decision-- In general, a decision by [*name of M+CO]* or a person acting on [*name of M+CO's*] behalf, to approve or deny a payment for a service or a request for provision of service made by you or on your behalf.

Lock-In -- An arrangement under which all covered services, except emergency services, urgently needed services, or out-of-area renal dialysis services, must be provided or authorized by your plan provider or your PCP. If you get any other services from a non-plan provider or a plan provider such as a specialist without prior authorization, neither *[name of M+CO*] nor Original Medicare will pay for that care. (There are very limited exceptions to this rule, including the right to self-refer for Flu Shots and Mammography Screening services. See the Schedule of Medical Benefits in Section 5 for specific limitations that apply to self-referral for these benefits).

Medical Director -- A licensed physician who is responsible for the overall quality of the medical care we provide.

Medicare --The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare+Choice Organization -- A public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide covered services. Medicare+Choice Organizations can offer one or more M+C Plans. *[Name of M+CO]* is a Medicare+Choice Organization.

Medicare+Choice Plan -- A benefit package offered by a Medicare+Choice Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare residing in the service area covered by the Plan. A Medicare+Choice Organization may offer more than one plan in the same service area. [N*ame of M+C Plan*] is a Medicare+Choice plan.

Member – A person with Medicare who is eligible to get covered services, who has enrolled in *[name of M+C Plan]*, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services -- A department within *[name of M+CO]* responsible for answering your questions about your membership, benefits, grievances, and appeals. A *[Name of M+CO]* Member Services representative is available to assist you during regular business hours by calling *[insert number, include TTY # - list hours of operation for both #s]*.

Network -- A group of health care providers under contract with [*name of M+CO*] that is licensed and/or certified by Medicare with the purpose of delivering or furnishing health care services. Generally, members must receive routine services within their designated network in order to be covered by [*name of M+CO*].

Non-Plan Provider or Non-Plan Facility -- Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services. This type of provider is not employed, owned, operated by, or under contract to deliver covered services to you.

Office Visit -- A visit for covered services to your PCP, specialist, other plan provider or non-plan provider upon referral.

Optional Supplemental Benefits -- Non-Medicare covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. Members of [*name of M+C Plan*] must voluntarily elect Optional Supplemental Benefits in order to get them.

Original Medicare -- A plan that is available everywhere in the United States. It is the way most

people get their Medicare Part A and Part B health care. (Original Medicare is also known as Fee-for-Service Medicare).

Peer Review Organization (PRO) -- Groups of practicing doctors and other health care experts who are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, and ambulatory surgical centers.

[NOTE: *Use the following (or a similar) definition of PHOs if your plan uses formal subnetworks where each enrollee, by selecting a specific PCP, is also selecting an entire subnetwork to which his or her PCP can make referrals. In addition to the definition, you should also include a complete explanation of this restriction in Section 3 - of this Model EOC]*.
Physician Hospital Organization (PHO) -- A contracting organization that requires physicians to use a specific hospital. In most cases, all hospital services, except for emergency and urgently needed services, must be obtained from the hospital with which your PCP is affiliated.

Plan Hospital -- A hospital that has a contract with *[name of M+CO*] or your plan medical group or IPA to give you services and/or supplies.

Plan Medical Group -- Physicians organized as a legal entity to provide medical care. The plan medical group has an agreement with the *[name of M+CO*] to provide medical services to you.

Plan Pharmacy -- A pharmacy that has an agreement to provide you the medication(s) prescribed by your Plan Provider.

Plan Premium -- The [*monthly/quarterly]* payment to *[Name of M+CO]* that entitles you to the covered services outlined in this Evidence of Coverage. (Note: To qualify for the services outlined in this EOC, you must also pay the monthly Medicare Part B Premium and, if applicable, Medicare Part A Premiums.)

Plan Provider -- A health professional, a supplier of health items, or a health care facility that has an agreement to provide or coordinate covered services to you.

Point of Service (POS) -- A benefit option under which *[name of M+C Plan]* allows members to get specified services if they are willing to pay higher cost-sharing amounts. This benefit may be offered as part of an M+C plan, or as a member option for an additional premium. [N*ame of M+C Plan] [offers/includes*] a Point of Service benefit.
[NOTE TO M+COs: *If you offer a POS option, also provide definitions of: Allowed Amount, Balance Billing, Coinsurance and Maximum Charge]*.

Prescription [Drug] Benefit Manager -- Companies that contract with Medicare+Choice Organizations to manage pharmacy services.

Primary Care Physician/Provider (PCP) -- A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing covered services while you are a member of [*name of M+C Plan*]. You are required to see your PCP for referral to a specialist. Sometimes PCPs are associated with a plan medical group or IPA.

Prior Authorization -- When a provider must obtain approval from a plan medical group, IPA, or [*name of M+CO*] before giving you certain health care services.

Provider -- A doctor, hospital, health care professional or health care facility licensed and/or certified by the State or Medicare to deliver or furnish health care services.

Referral -- Your PCP's *["or his/her plan medical group" or "IPA's"]* permission for you to see a certain specialist or to receive certain covered services.

Rehabilitative Services -- Services including physical, cardiac, speech, and occupational therapies that are rendered under the direction of a contracting health care provider.

Service Area -- A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which a Medicare+Choice eligible individual may enroll in a particular Medicare+Choice Plan offered by a Medicare+Choice Organization. This is the area within which you generally must get non-emergency and urgently needed services other than dialysis.

Skilled Nursing Care -- Services that can only be performed by or under the supervision of licensed nursing personnel.

Skilled Nursing Facility -- A facility (or distinct part of a facility) which is primarily engaged in providing to its residents skilled nursing or rehabilitation services and is certified by Medicare. The term "skilled nursing facility" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Specialist -- A doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (care for cancer patients), cardiologists (care for the heart), and orthopedists (care for bones).

Urgently Needed Services -- Services needed immediately as a result of an unforeseen illness, injury, or condition; and it is not reasonable given the circumstances to get the services through your PCP or other plan providers. Ordinarily, these services are provided when you are out of the service area. In extraordinary cases, these are services provided when you are in the service area, but plan providers are not available.

APPENDIX B More information about the appeals process: the six possible steps for making complaints related to your coverage or payment for your care

What is the purpose of this Appendix?

The purpose of this Appendix is to give you more information about a topic that is summarized briefly in Section 10 of this booklet, *Appeals and grievances: what to do if you have concerns or complaints*. Section 10 outlines the six possible steps in the appeals process for making complaints about your coverage or payment for your care. This Appendix goes through the same six steps in more detail. Since Section 10 also gives general information about making complaints, and discusses how to deal with other types of problems besides problems with coverage or payment for care, **you should read Section 10 before you read this Appendix.**

What are "complaints about your coverage or payment for your care"?

Complaints about your coverage or payment for your care are complaints you may have if you are not getting medical benefits and services you believe are covered for you as a member of [*name of M+C plan*], including payment for care received while a member of the [*name of M+C plan*]. Complaints about your coverage or payment for your care include complaints about the following situations:

- If you are not getting the care you want, and you believe that this care is covered by *[name of M+C plan]*
- If *[name of M+CO]* will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by *[name of M+C plan]*
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health
- If you have received care that you believe is covered by *[name of M+C plan]*, but we have refused to pay for this care

How does the appeals process work?

The six possible steps you can take to make complaints related to your coverage or payment for your care are described below. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one step to the next**. At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may deny (turn down) your request

completely. If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the medical care involved or on other factors.

- **"Initial decision" vs. "making an appeal."** Step 1 deals with the starting point for the appeals process. The decision made in Step 1 is called an "initial decision." If you continue with your complaint by going on to Step 2, it is called making an "appeal" or a "request for reconsideration" of our initial decision because you are "appealing" for a change in the initial decision that was made in Step 1. Step 2, and all of the remaining possible steps through Step 6, also involve *appealing* a decision.
- **Who makes the decision at each step**. In Step 1, you make your request for coverage of care or payment for care directly to *[name of M+CO]*. We review this request, then make an initial decision. If our initial decision turns down your request, you can go on to Step 2, where you "appeal" this initial decision (asking us to reconsider). After Step 2, your appeal goes outside of *[name of M+CO]*, where *people who are not connected to [name of M+CO] conduct the review and make the decision*. To help ensure a fair, impartial decision, those who make the decision about your appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.
- **A note about terminology**. Appendix A gives definitions for key terms in this booklet, including terms we use in this Appendix. In this Appendix, we tend to use simpler language instead of certain legal language, including terms that appear in the government regulations for the appeals process. For example, we generally say "initial decision" instead of "initial organization determination," and we generally use the word "fast" rather than "expedited" when referring to decisions that are made more quickly than the standard time frame. Instead of saying "adverse decision," we may say "deny your request," or "turn down your appeal." We use "independent review organization" rather than "independent review entity."

STEP 1: [Name of M+CO] makes an "initial decision" about your medical care, or about paying for care you have already received

What is an "initial decision"?

The "initial decision" made by *[name of M+CO]* is the starting point for dealing with requests you may have about your coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received. (This "initial decision" is sometimes called an "organization determination.") If our initial decision is to deny your request (this is sometimes called an "adverse initial decision"), you can "appeal" the decision by going on to Step 2 (see below). You may also go on to Step 2 (an "appeal") if we fail to make a timely "initial decision" on your request.

- If you ask *[name of M+CO]* to pay for medical care you have already received, this is a request for an "initial decision" about payment for your care. You can call us at *[phone number]* to get help in making this request.

- If you ask for a specific type of medical treatment from your doctor or other medical provider, this is a request for an "initial decision" about whether the treatment you want is covered by *[name of M+C plan]*. Depending on the situation, your doctor or other medical provider may make this decision on behalf of *[name of M+CO]*, or may ask us whether we will authorize the treatment. You may want to ask us for an initial decision without involving your doctor. You can call us at *[phone number]* to get help in making this request.

When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of *[name of M+C plan]* apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by *[name of M+C plan]*, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by *[name of M+C plan]*).

Who may ask for an "initial decision" about your medical care or payment?

You can ask us for an initial decision yourself, or you can name someone to do it for you. This person you name would be your *authorized representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and your authorized representative must sign and date a statement that gives this person legal permission to act for you. This statement must be sent to *[name of M+CO]* at *[address]*. You can call *[name of M+CO]* at *[insert number]* to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY [*insert number]*.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact *[Legal Agency Name]* at *[phone number] [include TTY # for the "hearing impaired"(if one is available) - list hours of operation.]*

"Standard decisions" vs. "fast decisions" about medical care

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days; see below), or it can be a "fast decision" that is made more quickly (typically within 72 hours; see below). A fast decision is sometimes called a 72-hour decision or an "expedited organization determination."

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for

medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to this address: *[name of M+CO], [address*].

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us at *[phone number]* (for TTY, call *[phone number]*). Or, you can deliver a written request to *[name of M+CO], [address]*, or fax it to *[fax number]*. Be sure to ask for a "fast" or "72-hour" review.

- If any doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor's support for a "fast" review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 14 calendar days; see below).

What happens when you request an "initial decision"?

What happens, including how soon we must decide, depends on the type of decision:

1. *For a decision about payment for care you already received:*

After we receive your request, we have 30 calendar days to make a decision. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 calendar days of your request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then appeal this decision. (An appeal is also called a reconsideration.) Step 2 tells how to file this appeal.

2. *For a <u>standard</u> initial decision about medical care:*

After we receive your request, *[name of M+CO]* we have up to 14 calendar days to make a decision, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision (a) if you request this extension of time, or (b) if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records).

When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a "grievance." Section 10 of this booklet, *Appeals and grievances: what to do if you have concerns or complaints,* tells how to make this kind of complaint.

We will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Step 2 tells how to file this appeal.

If you have not received an answer from us within 14 calendar days of your request for the initial decision, this failure to receive an answer is the same as being told that your request was not approved, and you have the right to appeal. If we tell you that we extended the number of days needed for a decision and you have not received an answer from us by the end of the extension period, this failure to receive an answer is the same as being told that your request was not approved, and you do not have the right to appeal. Step 2 tells how to file this appeal.

3. *For a fast initial decision about medical care:*

If you receive a "fast" review, we will give you the result of our decision about your medical care within 72 hours after you or your doctor ask for a "fast" review -- sooner if your health requires. However, we are allowed to take up to 14 more calendar days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you can make a specific type of complaint called a "grievance." Section 10 of this booklet, *Appeals and grievances: what to do if you have concerns or complaints,* tells how to make this kind of complaint.

We will tell you our decision by phone as soon as we make the decision. Within three calendar days after we tell you of our decision in person or by phone, we will send you a letter that explains the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If we deny your request for a fast decision, you may file a grievance about this decision. Section 10 of this booklet, *Appeals and grievances: what to do if you have concerns or complaints,* tells how to file a grievance.

What happens next if we decide completely in your favor?

If we make an "initial decision" that is completely in your favor, what happens next depends on the situation:

1. *For a decision about payment for care you already received:* We must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.

2. *For a standard decision about medical care:* We must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received the request you made for the initial decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision.
3. *For a fast decision about medical care:* We must authorize or provide you with the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must provide it sooner.

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for care that you have already received, we may say that we will pay nothing or only part of the amount you requested. In denying a request for medical care, we might decide not to approve any of the care you want, or only some of the care you want. If any initial decision does not give you *all* that you requested, you have the right to ask us to reconsider the decision, as explained below in Step 2.

STEP 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an "appeal" or "request for reconsideration."

Please call us at *[telephone number]* if you need help in filing your appeal. You may ask us to reconsider the initial decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" *appeal* in Step 2 are the same as those described for a "standard" or "fast" *initial decision* in Step 1. Please see the discussion in Step 1 under "Do you have a request for medical care that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision." *[Note: M+COs that have their appeals sent to a different office than organization determinations should mention that while the process for deciding on a standard or fast appeal are the same as in Step 1, the place where the appeal is sent is different; also include instructions for where to send appeal requests.]*

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. You have the right to obtain and include additional information as part of your appeal. For example, you may already have

documents related to the issue, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to *[name of M+CO], [insert address]*.
- By fax, at *[insert number]*.
- By telephone -- if it is a "fast" appeal -- at *[insert number]*.

You also have the right to ask us for a copy of your file that contains the information regarding your appeal. You can call or write us and ask for a copy of your file at [*insert number]*; *[name of M+CO], [insert address]*. *[Insert if a fee is charged:* We are allowed to charge a fee for copying and sending this information to you.]

How do you file your appeal of the initial decision?

The rules about who may file the appeal in Step 2 are the same as the rules about who may ask for an "initial decision" in Step 1. Please follow the instructions in Step 1 under "Who may ask for an 'initial decision'" about medical care or payment?"

Either you, someone you appoint, or your provider may file this appeal.

However, providers who do not have a contract with *[name of M+C plan]* must sign a "waiver of payment" statement which says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

The appeal should be given to us in writing at *[name of M+CO], [insert address],* within 60 calendar days after we notify you of the initial decision from Step 1. We can give you more time if you have a good reason for missing the deadline.

You may also send your appeal to your Social Security Administration office or, if you are a railroad retiree, to a Railroad Retirement Board Office. Please note that sending your appeal to either of these offices instead of to us will delay when we begin the appeal, since these offices must forward your appeal request to us.

What if you want a "fast" appeal?

The rules about *asking for a "fast" appeal* in Step 2 are the same as the rules about *asking for a "fast" initial decision* in Step 1. If you want to ask for a "fast" appeal in Step 2, please follow the instructions in Step 1 under "Asking for a fast decision." *[Note: M+COs that have their appeals sent to a different office than organization determinations should mention that while the process for deciding on a standard or fast appeal are the same as in Step 1, the place where the appeal is sent is different; also include instructions for where to send appeal requests.]*

How soon must we decide on your appeal?

How quickly we decide on the appeal depends on the type of appeal:

1. *For a decision about payment for care you already received:* After we receive your appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your appeal *automatically* goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care:* After we receive your appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30 calendar days (or by the end of the extended time period), your request will *automatically* go to Step 3, where an independent organization will review your case.

3. *For a fast decision about medical care:* After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about payment for care you already received:* We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision. If we decide only partially in your favor, your appeal automatically goes to Step 3, where an independent organization will review your case.
2. *For a standard decision about medical care:* We must authorize or provide you with the care you have asked for as quickly as your health requires, but no later than 30 calendar days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.
3. *For a fast decision about medical care:* We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal -- or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your appeal?

If we deny any part of your appeal in Step 2, then your appeal *automatically* goes on to Step 3 where an independent organization will review your case. This independent review organization contracts with the federal government and is not part of *[name of M+CO*]. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the independent review organization that performs the review in Step 3 depends on the type of appeal:

1. *For a decision about payment for care you already received:* We must send all the information about your appeal to the independent review organization within 60 calendar days from the date we

received your appeal in Step 2.

2. *For a standard decision about medical care:* We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your appeal in Step 2.

3. *For a fast decision about medical care:* We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

STEP 3: If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization

What independent review organization does this review?

In Step 3, your appeal is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to *[name of M+CO]*. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization. *[M+COs: Insert if you charge a fee:* We are allowed to charge you a fee for copying and sending this information to you.]

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. *For an appeal about payment for care,* the independent review organization has up to 60 calendar days to make a decision.

2. *For a standard appeal about medical care,* the independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

3. *For a fast appeal about medical care,* the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For an appeal about payment for care,* we must pay within 30 calendar days after receiving the decision.

2. *For a standard appeal about medical care,* we must *authorize* the care you have asked for within

72 hours after receiving notice of the decision from the independent review organization, or *provide* the care as quickly as your health requires, but no later than 14 calendar days after receiving the decision.

3. *For a fast appeal about medical care,* we must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You may continue your appeal by asking for a review by an Administrative Law Judge (see Step 4), provided that the dollar value of the medical care or the payment in your appeal is $100 or more.

You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date you were notified of the decision made in Step 3. You can extend this deadline for good cause. You have a choice about where you send your written request:

- You can send it directly to the independent review organization that reviewed your appeal in Step 3. They will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal in Step 4.
- Instead of sending your request directly to the independent review organization that reviewed your appeal in Step 3, you can send it to *[name of M+CO]*, or to your local Social Security Administration office. If you do this, starting Step 4 will take longer because your request must first be forwarded to the independent review organization that reviewed your appeal in Step 3. The independent review organization will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal in Step 4.

STEP 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated in Step 3, if the independent review organization does not rule completely in your favor, you may ask them to forward your appeal for a review by an Administrative Law Judge. The Administrative Law Judge will not review the appeal if the dollar value of the medical care is less than $100. If the dollar value is less than $100, you may not appeal any further.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor:

We must pay for, authorize, or provide the service you have asked for within 60 calendar days from the

date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Departmental Appeals Board (Step 5).

If the Judge rules against you:

You have the right to appeal this decision by asking for a review by the Departmental Appeals Board (Step 5). The letter you get from the Administrative Law Judge will tell you how to request this review.

STEP 5: Your case is reviewed by a Departmental Appeals Board

This Board will first decide whether to review your case

If the Departmental Appeals Board decides not to review your case, then either you or *[name of M+CO]* may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is $1,000 or more. If the dollar value is less than $1,000, you may not appeal any further.

How soon will the Board make a decision?

If the Departmental Appeals Board reviews your case, they will make their decision as soon as possible.

If the Board decides in your favor:

We must pay for, authorize, or provide the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least $1,000. If the dollar value is less than $1,000, the Board's decision is final.

If the Board decides against you:

If the amount involved is $1,000 or more, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than $1,000, you may not take the appeal any further.

STEP 6: Your case goes to a Federal Court

If the amount is $1,000 or more, you or *[name of M+CO]* may ask a Federal Court Judge to review the case.

APPENDIX C. Legal Notices

Notice about governing law:

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The laws that may apply to this document are: all of the laws of the State(s) of *[insert name or names of states]* and the United States of America, including Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS (formerly known as the Health Care Financing Administration, or HCFA). If this Evidence of Coverage and a law are inconsistent or in conflict, the law will decide what should happen.

Notice about non-discrimination:

When *[name of M+CO]* makes decisions about employment of staff or provides health care services, it does not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare managed care, like *[name of M+CO]*, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

[The M+CO may include other legal notices, such as a notice of member non-liability, notice about third party liability, notice about acts beyond the control of the M+CO (e.g., act of insurrection, natural disaster), etc. These notices may only be added if they conform with Medicare laws and regulations and/or State laws that do not conflict with Federal laws.]

APPENDIX D. Information about "a*dvance directives*" (Information about using a legal form such as a "living will" or "power of attorney" to give *directions in advance* about your health care in case you become unable to make your own health care decisions)

You have the right to make your own health care decisions. But what if you had an accident or illness so serious that you *became unable* to make these decisions for yourself? If this were to happen:

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care providers know the types of medical care you would *want* and *not want* if you were not able to make decisions for yourself.
- You might want to do both – to appoint someone else to make decisions for you, and to let this person and your health care providers know the kinds of medical care you would want if you were unable to make these decisions for yourself.

If you wish, you can fill out and sign a special form that lets others know what you want done if you cannot make health care decisions for yourself. This form is a legal document. It is sometimes called an **"advance directive,"** because it lets you give *directions* in *advance* about what you want to happen if you ever become unable to make your own health care decisions.

There are different types of advance directives and different names for them depending on your state or local area. For example, documents called "living will" and "power of attorney for health care" are examples of advance directives.

It's *your choice* whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether you have an advance directive or not.

How can you use a legal form to give your instructions in advance?

If you decide that you do want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, and from some office supply stores *[M+COs can list themselves as a contact if they provide these forms]*. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for **S**tate **H**ealth **I**nsurance Assistance **P**rogram). Section 1 of this booklet, *Telephone numbers and other information for reference,* tells how to contact your SHIP (SHIPs have different names depending on which state you are in). Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. If you know ahead of time that you are going to be hospitalized, take a copy with you.

If you are hospitalized, they will ask you about an advance directive

If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one. It is *your choice* whether to sign or not. If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given.

What if providers don't follow the instructions you have given?

If you believe that a doctor or hospital has not followed the instructions in your advance directive you may file a complaint with *[list appropriate state-specific agency here, such as State Department of Health. Provide contact information]*.